Women and Infant Health Project Facility Survey 2000

Report of Main Findings

Patricia H. David
Senior Evaluation Advisor
John Snow Inc.
Boston, Massachusetts USA

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AIDS	Acquired Immuno-Deficiency Syndrome
AVSC	Association for Voluntary and Safe Contraception
CDC	Centers for Disease Control and Prevention
FCMC	Family-Centered Maternal Care
FP	Family Planning
HIV	Human Immuno-deficiency Virus
IEC	Information, Education, Communication
ID	Identification
IUD	Intra-Uterine Device
JSI	John Snow, Inc.
LAM	Lactational amenorrhea method
SPSS	Statistical Package for the Social Sciences
STD	Sexually Transmitted Disease
TV	Television
USAID	United States Agency for International Development
VCIOM	Russian Center for Public Opinion and Market Research
WIN	Women and Infant Health Project
WHO	World Health Organization

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EXECUTIVE SUMMARY

Background

The Women and Infant Health Project (WIN) is a USAID-funded project that aims to improve the effectiveness and 'family-friendliness' of maternal and infant health services by training women's health care providers in evidence-based medical practices. The project is establishing training programs and information, education and communication(IEC)/counseling interventions in three Russian cities for providers of a range of women's and newborn health services, and their clients. A pre-intervention survey of provider practices and client experiences was conducted in participating facilities to inform training programs, measure indicators of project effectiveness, and stimulate policy change.

This facility-based survey is a component of the evaluation designed for the WIN Project, which will pre- and post-intervention household and facility surveys and a routine monitoring system to track key indicators within participating facilities. The evaluation is designed to assess the effectiveness and impact of the project established in participating facilities in the three cities, Veliky Novgorod, Perm and Berezniki.

The focus of WIN interventions is on maternal and newborn health and nutrition, including promotion of exclusive breast feeding, family planning services for postpartum and post-abortion clients, protection against domestic violence, essential care of the newborn, and family-centered maternity care as a component of antenatal, delivery and postpartum care.

The project interventions consist of clinical and counseling training for health providers at all levels, community-based and facility-based information, education and communication (IEC) strategies for both families and providers, and advocacy and policy promotion. The training aims to reduce unnecessary medical intervention during pre-natal, delivery and neonatal care, and to improve postnatal and post-abortion contraceptive counseling. The ultimate aim is to institute evidence-based medical practices more widely to improve the effectiveness and 'family-friendliness' of maternal and infant health services delivered by the Russian health care system.

The WIN Project is funded by the United States Agency for International Development, and is implemented by John Snow, Inc. Collaborating partners include the Ministry of Health of the Russian Federation; the Association for Voluntary and Safe Contraception; the University Research Center Quality Assurance Project; Johns Hopkins University Center for Communication Programs; and the All-Russia Center for Public Opinion Research (VCIOM).

Survey Objectives

A quantitative survey of providers and clients in 20 participating health facilities in three Russian cities was conducted in early 2000, prior to the start of project interventions. The aim of the survey is to provide pre-intervention data to measure changes in selected indicators of effectiveness and impact achieved by the project. The data will also be used to provide quantitative information on current practices and knowledge to 'fine-tune' training programs, and to provide a firm basis for policy discussions.

Methodology

The baseline facility survey obtained quantitative data from 497 providers and 1304 clients in maternity hospitals, women's consultation centers and children's polyclinics in three Russian cities. Medical students and interns administered four survey instruments designed for the Russian health care context. A Russian survey coordinator and US-based survey director trained the interviewers and their three field supervisors, who were senior public health administrators in the participating cities. Over the course of three weeks, medical staff providing prenatal, abortion and delivery services, and neonatal or pediatric care were interviewed. The universe of physicians working in targeted facilities, a systematic random sample of half of all midwives and infant nurses, and at least 300 women coming to these facilities for each type of service (delivery and postpartum care, prenatal care, and abortion services) were targeted for interview.

Client sample size was calculated using prevalence estimates for selected indicators and a one-tailed test with 80% power to detect expected changes. A Russian survey research organization was responsible for data entry, and data were analyzed using the SPSS statistical package by US-based staff.

The analyses are based on aggregated reports of individual respondents and provide estimates reflecting knowledge and reported practices of the average provider and experiences of the average client in the entire network of participating facilities. No analyses were performed that would enable identification of individual providers or clients.

Results

A total of 548 providers were contacted for interview. Of these providers, 51 refused to be interviewed and one started but did not complete the interview. Completion rates were fairly similar for all specialties, and ranged from a high of 96% of all providers in Veliky Novgorod to only 87% in Perm and 90% in Berezniki who agreed to be interviewed. The total number of providers successfully interviewed was 497.

Three hundred and twenty-four women were interviewed in the postpartum period, either prior to discharge from the maternity where the birth took place, or within four months of the birth while attending a children's polyclinic with their infant. Four hundred and ninety-one antenatal clients and 489 abortion clients were also interviewed.

Quantitative measures of key program effectiveness indicators using both provider and client reports were calculated. Monitoring indicators include knowledge of exclusive breastfeeding, women ambulatory during labor, women delivering with support of a family member, postpartum contact between mother and newborn, and the percent of postpartum and post-abortion clients who receive family planning counseling prior to discharge.

Information obtained from providers also included prenatal prescribing practices, medication to induce labor and during labor, and knowledge and postpartum practice of skin-to-skin contact and immediate breastfeeding. Both provider and client-based reports of post-abortion care and the content of contraceptive counseling (including LAM) prior to discharge were also measured.

Of women who had had more than one pregnancy (including the current one) more than three-quarters of antenatal, postpartum and abortion clients had least one previous abortion. Of those repeat abortion clients, 40% had terminated a pregnancy by abortion within the previous calendar year.

Information obtained from providers about 'usual practices' was sometimes inconsistent with client reports. Only 23% of antenatal clients reported discussing contraception with medical staff at the facility. Only 41% of post-abortion and 19% of postpartum clients received family planning counseling prior to discharge. However, 62% of antenatal caregivers, 69% of delivery caregivers and 92% of abortion providers reported that they discuss contraception with their clients.

80% of delivery care providers reported offering 'rooming-in' to mothers, but only 38% of mothers said their baby stayed with them day and night. More than half of these babies (62%) were taken to the nursery for the first night. Of mothers who did not have rooming-in, 87% said they were never offered the option.

Women start out to breastfeed their babies; 84% of postpartum women reported that they were currently breastfeeding. Of those, 70% said their baby was given something to drink from a bottle during the hospital stay (and 7% did not know if the baby was fed something else). Yet only 28% of postpartum women said they fed 'on demand' and 67% fed on a schedule (5% said they fed when the staff brought the baby).

56% of antenatal clients and 49% of postpartum women can correctly define 'exclusive breastfeeding' (breast milk and nothing else except vitamins, minerals or medicine). But, according to the same definition, only a little more than 25% of delivery and neonatal caregivers tell their clients to breastfeed exclusively for a full six months. Furthermore, almost one-half of all postpartum women (46%) said they were advised to supplement their breast milk with water.

One of the characteristics of 'family-centred maternity care' is closer contact between mother and baby and more involvement by other family members in antenatal preparations for the birth, and support during labor and in the postpartum period. We found that in participating facilities, 96% of women said they had no close person supporting them at the birth.

Other discrepancies between provider and client reports highlight issues of quality of care from a client perspective. For example, 90% of abortion providers said they explain the procedure to clients prior to performing an abortion, yet only 56% of clients reported receiving such information.

Further, 78% of providers said an enema was usual practice for all women (22% said only for some women), but 92% of postpartum women report having an enema. Thirty-six percent of providers said giving IV solution was usual practice for all women (64% said only for some women), but 85% of postpartum women report having an IV solution during labor. Only two percent of providers said medicine to induce labor was usual practice for all women (98% said only for some women), but almost half of postpartum women (47%) report that their labor was induced. Thirty-one percent of providers said allowing women to sit up during labor was the usual practice for all women, and 56% of postpartum women report they were <u>not</u> allowed to sit up during their labor.

Conclusions

Quantitative data obtained using sound methodologies are essential for project evaluation. These data can also be used to attain project objectives by providing a firm basis for policy discussions. Baseline data can be used to stimulate action by policy-makers to change long-entrenched but unproven or unnecessary practices.

Several conclusions we draw from these data are:

- The prevalence of abortion and repeated abortion by all types of clients is high.
- Contraceptive counseling in all women's health services is currently inadequate.
- Many women can define exclusive breastfeeding, but few providers actually counsel women to breastfeed exclusively for the first 6 months.
- The effectiveness of some widespread practices (some antenatal prescribing practices, and some practices followed for labor, delivery and newborn care) is not supported by scientific evidence, and some are potentially harmful.

Our findings show that information obtained from providers was sometimes inconsistent with client reports. This suggests that, while many providers know what constitutes good practice, some are inconsistent in applying this knowledge.

These and other findings could be used to stimulate discussion and action among facility staff and policy-makers.

1. INTRODUCTION

Background

This survey is a component of the evaluation designed for the Women and Infant Health Project (WIN), a USAID-funded project. The WIN Project is establishing training programs and IEC/counseling interventions in three Russian cities for providers of a range of women's and newborn health services and their clients. The project trains Russian obstetricians, gynecologists, neonatologists, pediatricians, midwives and infant nurses in evidence-based medical practices.

The focus of WIN interventions is on maternal and newborn health and nutrition, including promotion of exclusive breast feeding, family planning services for postpartum and post-abortion clients, protection against domestic violence, essential care of the newborn, and family-centered maternity care as a component of antenatal, delivery and postpartum care.

The project interventions consist of clinical and counseling training for health providers at all levels, community-based and facility-based information, education and communication (IEC) strategies for both families and providers, and advocacy and policy promotion. The interventions are guided by the following principles:

- Use of evidence-based medicine to enhance clinical practice
- Use of quality assurance methods involving both providers and clients in provision of quality services
- Promotion of a client-oriented focus
- Continuity and consistency in client-provider communications and across service levels.

The training aims to reduce unnecessary medical intervention during pre-natal, delivery and neonatal care, and to improve postnatal and post-abortion contraceptive counseling. Another component of the project is production of appropriate health messages and materials to inform and educate the population in the three target cities, and for use in participating facilities. The ultimate aim is to institute evidence-based medical practices more widely to improve the effectiveness and 'family-friendliness' of maternal and infant health services delivered by the Russian health care system.

The WIN Project Evaluation Strategy

The WIN Project will be evaluated using a suite of methods: pre- and post-intervention household and facility surveys, and a routine monitoring system to track key indicators within participating facilities. The evaluation is designed to assess the effectiveness and impact of the project established in participating facilities in the three cities, Veliky Novgorod, Perm and Berezniki.

The evaluation component of the project will use data to:

- provide quantitative information on current practices and knowledge to 'fine-tune' training programs
- monitor progress during the project in order to adjust project activities as necessary
- measure change in selected indicators of effectiveness and impact achieved by the project
- provide a firm basis for policy discussions.

At the start of the project, two surveys were conducted: a household survey of populations in the three cities, and a facility survey, which interviewed providers and clients in all participating facilities in the three cities. A system to monitor key health and process indicators was instituted in participating health facilities, and at the city and oblast level.

This report describes the results of the baseline facility survey.

Objectives of the Survey

This survey of women's health care providers and clients in targeted facilities specifically aims to obtain baseline information on provider practices that are the focus of project interventions and on client reports of their experiences and satisfaction with the care they receive. The purpose is to obtain pre-intervention data as a baseline to measure changes in selected indicators of effectiveness and impact achieved by the project. The data will also be used to provide quantitative information on current practices and knowledge to 'fine-tune' training programs, and to provide a firm basis for policy discussions.

2. METHODOLOGY

Questionnaire Design

The facility survey questionnaires draw on instruments developed by the Population Council for situation analyses of family planning facilities in other parts of the world, and by the MEASURE Evaluation Project assessment of the quality of family planning and reproductive health services. The WIN Project survey instruments were designed by JSI's technical advisor for evaluation and finalized in consultation with WIN Project staff and project partners.

Four interview questionnaires were prepared: one for providers of each type of care (abortion, antenatal, delivery and postpartum and neonatal services); and one for each group of clients (abortion recipients, antenatal care attendees, and women recently delivered). Postpartum women were interviewed either just prior to discharge from a maternity ward or when they brought their newborns to children's polyclinics (up to several months postpartum).

Russian translations of the four questionnaires were pre-tested twice in non-participating facilities in a city near Moscow. One pretest was completed prior to the training program for field staff. During the field staff training program, a second field test was conducted, which disclosed the need for further adjustments to question categories and clarification of filter questions. The final translation of the questionnaires was then prepared, and the questionnaires duplicated and sent to field supervisors in the week following the end of the training program.

Sample

To calculate sample size, we estimated the pre-intervention prevalence of key indicators, and a minimum expected change that we wanted to detect[1] at the end of the project. Resources dictated that the field work could be maintained for no longer than three weeks, which we estimated would allow for interviews with all selected medical providers (estimated at about 425), and a minimum of 300 women who had recently given birth. Three hundred postpartum women was the minimum feasible sample size we estimated would be sufficient to estimate change in several key indicators between the baseline and end line surveys.

The providers to be contacted were the universe of physicians working in facilities participating in the project (see below) who provide antenatal, abortion, delivery and postpartum services, neonatal/pediatric care and family planning counseling. A complete list of all medical staff at participating facilities was obtained, along with the timing of their special clinics or days that they are in attendance at the hospital or clinic, in order to ensure that interviewers could be assigned to complete interviews with each staff member.

Midwives and nurses follow similar protocols for the care they provide and have less flexibility in their practices than physicians. A systematic random sample of half of all hospital midwives and pediatric nurses providing these services was selected for interview from staff lists.

In all, 548 providers were selected for interview (all physicians and half the midwifery and pediatric nursing staff), and a total of 497 consented and completed interviews. The refusal rate among providers was 9.5% (51 refusals and one incomplete interview).

[1] All calculations were based on 95% confidence limits (the probability that the observed change is due to chance is less than 5%), a one-tailed test with 80% power (the probability of observing a change of the expected magnitude when the 'true' change falls within the confidence limits).

In addition, all female clients coming to each participating facility during a three week period for the same services were invited to participate (a 'take-all' sampling strategy during a fixed data collection period). The frequency of women attending abortion and antenatal services far exceeds the number of births in these cities. An estimate of the patient load for abortion and delivery (postpartum) patients was obtained from annual number of births and abortions per facility. As mentioned earlier, a total sample of 300 women who had recently given birth (inpatients and women coming for postpartum or neonatal care after delivery) was sought. This number of respondents was deemed sufficient to provide reliable estimates of change in selected indicators (total across all 3 cities) between the pre- and post-intervention surveys.

During the time period of data collection, all women coming for antenatal, and abortion services at the target facilities who consented were also interviewed, with a minimum sample of 300 women coming for each type of service. The survey coordinator kept a running tally of completed interviews, and field supervisors in the three cities were instructed to stop all interviews when the requisite sample of postpartum clients was reached. The final sample of clients thus obtained was 491 women coming for antenatal care, 489 abortion clients, and 324 postpartum women.

Field Implementation, Data Editing and Entry

Nineteen medical students and interns and three senior medical administrators were recruited in the three cities to assist with fieldwork. In early February 2000 a five-day training course for field staff was held in Moscow, conducted by the local Russian survey coordinator, an experienced epidemiologist, and WIN's evaluation advisor. The course included one day of field practice in facilities in a city near Moscow. During this field practice, additional clarifications and adjustments to the questionnaires were noted, and discussed with all field staff during the final day of training. These changes were made to the questionnaires prior to final production.

Prior to fieldwork, central survey staff estimated the expected number of births in each city during the three-week period, and informed the city supervisors of the approximate number of postpartum clients expected to be available for interview (in proportion to the birth rate in each city). This was estimated to be about 150 clients (50% of the total sample) in Perm, 90 clients (30%) in Veliky Novgorod, and 60 postpartum clients (20%) in Berezniki. The actual proportions of postpartum clients interviewed in each city came quite close to this approximation: 31.6% of all the postpartum interviews (of the total 324) were conducted in Veliky Novgorod, 46% in Perm and 22.2% in Berezniki.

One supervisor in each city, reporting daily to the survey coordinator in Moscow by telephone, assigned interviewers to providers and client locations, keeping track of interviews that were refused or were impossible to complete.

Central project staff sent a letter to each facility director, explaining the purpose of the survey and enlisting his or her cooperation. The survey was then launched with the help of the Moscow-based survey coordinator, who visited each city in succession in the second week following training. On this visit the Russian coordinator met with facility directors and city supervisors, assisted with coding and sampling for the provider survey, and assisted the local supervisor with scheduling initial interviews and logistics.

Facility directors were also asked to complete a facility data sheet that obtained baseline information on the number of abortions, antenatal clients, live births, and stillbirths, neonatal and

maternal deaths for the previous calendar year. Interviews were conducted between 14 February and 18 March 2000, beginning with the launch in Veliky Novgorod, following in Perm, and finally in Berezniki.

Interviewers were assigned specific times to cover client interviews in facilities and instructed to approach each client after she emerged from her visit with the provider, asking for her cooperation in answering 'some questions about maternal and child health issues'. Interviewers were assigned a private area in which to conduct the interviews. They read a greeting, which briefly explained the purpose of the WIN Project and asked for each woman's consent to ask questions about her experiences at the facility. The client's name was not recorded on the questionnaire.

Despite instructions to complete questionnaires for all women approached for interview, proceeding with further questions only after obtaining consent, no information was obtained regarding the number of clients who refused to participate in the survey. No refusals or incomplete interviews were recorded on the cover sheet of any returned client questionnaires, but one supervisor reported that one postpartum woman who had a stillbirth refused. We compared the numbers of abortion and delivery clients interviewed with monthly totals from the facilities in each city. Daily averages were almost identical in Novgorod and Berezniki, and slightly below the facility reported averages in Perm (where overall client loads are higher). Our data suggest that almost all clients were interviewed, but it is not possible to identify how many women actually refused interview, nor how many were lost because interviewers were busy with other clients.

Codes were assigned to each facility and each provider, to enable the survey coordinator and field supervisors to track interviews completed and those providers who refused to participate. The key to these code numbers was retained in Moscow headquarters, and was unknown to the survey analysts. In order to ensure that all providers selected for interview were approached, the supervisor checked off the provider ID number as the questionnaires were completed. Interviewers read a statement to each provider, requesting consent to the interview and assuring confidentiality.

The city supervisor scheduled provider interviews, assigning interviewers to specified individuals. While these appointments could not be anonymous, the survey-assigned provider code number was the only identification recorded on the questionnaire itself. Questionnaires were carefully guarded, and the interviewers instructed not to show them to anyone except their supervisor, who collected completed questionnaires each day, and stored them until they could be sent to Moscow headquarters.

After review by the field supervisor, completed questionnaires were shipped to Moscow headquarters, where central staff coded open-ended questions and completed office editing. The edited questionnaires and coding key for open-ended questions were sent to the All-Russian Centre for Public Opinion and Market Research (VCIOM), where the data entry programs were written and the data entered into computer files. These files were produced in an English version ready for analysis with the SPSS statistical analysis package.

Analysis

All results are based on *reports* from either providers or clients – knowledge, attitudes and usual practices reported by providers, and experiences and satisfaction with services reported by abortion, antenatal and postpartum clients. Many providers may be aware of what the 'correct'

practice ought to be, and answer accordingly, but perhaps contrary to their usual practices. However, it is possible to assess whether this knowledge is routinely translated into actual clinical *practice* by assessing the experience of the average client.

In contrast, many facility surveys rely not only on reported knowledge and practices, but also on an assessment of clinical practice by independent observers. Such observations of provider-client interactions are highly time-intensive and require that observers are themselves fully trained in the evidence-based practices and counseling skills that are the objects of interest. While observations of actual provider-client interactions would enrich our data, neither this resource base of knowledgeable providers nor the time to conduct such observations was available before the WIN Project training activities started. The survey organizers deemed it infeasible to attempt observations in the short time frame available to obtain baseline data. Instead, we compare client reports of their experiences in these facilities with the practices providers report.

Except in a few cases, the sample size precludes analysis at city or facility level. The analyses in the following chapters are based on aggregated reports of individual respondents and are expected to provide reliable estimates reflecting knowledge and reported practices of the average provider and experiences of the average client in the entire network of participating facilities. No analyses were performed that would enable identification of individual providers or clients.

3. CHARACTERISTICS OF THE STUDY GROUPS

Facilities

Providers and clients in the 20 participating facilities in Veliky Novgorod, Perm and Berezniki were interviewed. The distribution of facilities by city and by type of service is shown in Table 3.1.

Table 3.1 Number and distribution of participating facilities by city and service type

TYPE OF HEALTH FACILITY	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Maternity	2	2	1	5
Women's consultation	3	2	1	6
Children's polyclinic	3	2	1	6
Family planning center		2	1	3
Total	**8**	**8**	**4**	**20**

Health Care Providers

A total of 548 providers were contacted for interview. Of these providers, 51 refused to be interviewed and one started but did not complete the interview. (Nine refusals occurred in facilities in Veliky Novgorod, 35 refusals[2] in Perm, and 8 refusals occurred in Berezniki.) Completion rates for provider interviews ranged from a high of 96% of all provider interviews in Veliky Novgorod to only 87% in Perm and 90% in Berezniki. Ninety-two percent of the sampled providers were women, and 98% of those who refused were women. Completion rates were fairly similar for all specialties, ranging from 88% of midwives and gynecologists to 95% of pediatricians.

The total number of providers successfully interviewed was 497. The distribution of these providers by their clinical specialty, city and type of facility are shown in Table 3.2.

[2] The one incomplete interview occurred in Perm and is included in 'refusals'.

Table 3.2 Number of providers interviewed according to specialty, type of facility and city

	NUMBER (N=497)
Specialty	
Obstetrician (including 123 who designated themselves as ob-gyn)	148
Gynecologist	15
Neonatologist	38
Pediatrician	97
Midwife	111
Children's nurse	79
Other	8
Missing	1
Facility Type	
Maternity	218
Hospital Gynecology Unit	13
Women's consultation	107
Children's polyclinic	144
Family planning center	15
City	
Veliky Novgorod	194
Perm	235
Berezniki	68

Service providers ranged in age from 20 years to more than 60 years of age (Table 3.3). The average provider had worked at the facility for 12 years (about the same for all specialties, ranging from an average of 9 years for gynecologists to 13 years for obstetricians (data not shown). Obstetricians, gynecologists, and pediatricians were, on average, about 4 years older (41-42 years of age) than midwives, children's nurses, and neonatologists (35-36 years of age).

Table 3.3 Age distribution and training profile of providers

10 YEAR AGE GROUP	PERCENT (N=497)
20–29	21.4
30–39	29.5
40–49	32.6
50–59	12.4
60+	4.1
Years since last training	
< 1	40.4
1–2	17.0
2+	42.6

In the follow-up survey that will be conducted at the end of the project, it will be important to examine differences between providers who received training through project activities and those who do not participate in any project training. Providers were asked about their recent experience of in-service training. About 40% of the providers reported attending some kind of training course during the preceding year, and more than 40% had not received any training for more than 2 years (Table 3.3).

Table 3.4 Percent providing services by clinical specialty and type of services

TYPE OF PROVIDER	PROVIDES ABORTION OR RELATED SERVICES	PROVIDES NEONATAL SERVICES	PROVIDES DELIVERY OR POSTPARTUM CARE	PROVIDES ANTENATAL CARE	PROVIDES CONTRACEPTIVE COUNSELING
Obstetrician	63.1**	8.5	57.0	65.3	61.1
Gynecologist	14.6		0.01		6.8
Neonatologist		14.7	0.01		0.5
Pediatrician		36.3			3.6
Midwife	17.5	10.4	41.3	33.7	24.9
Children's		30.1			0.5
Other	4.9			1.0	2.7
Total Percent (Number of respondents)	100 (103)	100 (259)	100 (121)	100 (98)	100 (221)
Percent of all providers (N=497)	20.7	51.2	24.3	19.7	44.5

** Of those providers who said they perform abortions, 63% were obstetricians
Note: Row percentages do not add to 100%, because some providers provide more than one service.

The distribution of medical staff by the type of services they provide is shown in Table 3.4. Less than half of these 497 providers of health care services to women and their newborns reported that they also gave counseling about contraceptives in the 3 months prior to the survey. We look more closely at the composition of providers who do contraceptive counseling in Chapter7.

Client Profiles

The demographic characteristics of different types of clients for women's health care services are shown in Table 3.5. We can see that the sample of clients interviewed was distributed among the three cities in about the same proportions as we had anticipated when planning the survey (Table 3.5). About 30% of all clients were from Veliky Novgorod, just under half were from Perm, and about a quarter of our client interviews were conducted in Berezniki, the smallest of the three cities. This mirrors quite closely the proportionate distribution of the sample based on birth rates and population in the three cities (see Chapter 2).

Antenatal clients were, on average, younger than postpartum and abortion clients. More abortion clients than the other client groups were older than 35 years. The age distribution of the three client samples is shown in Figure 3.2.

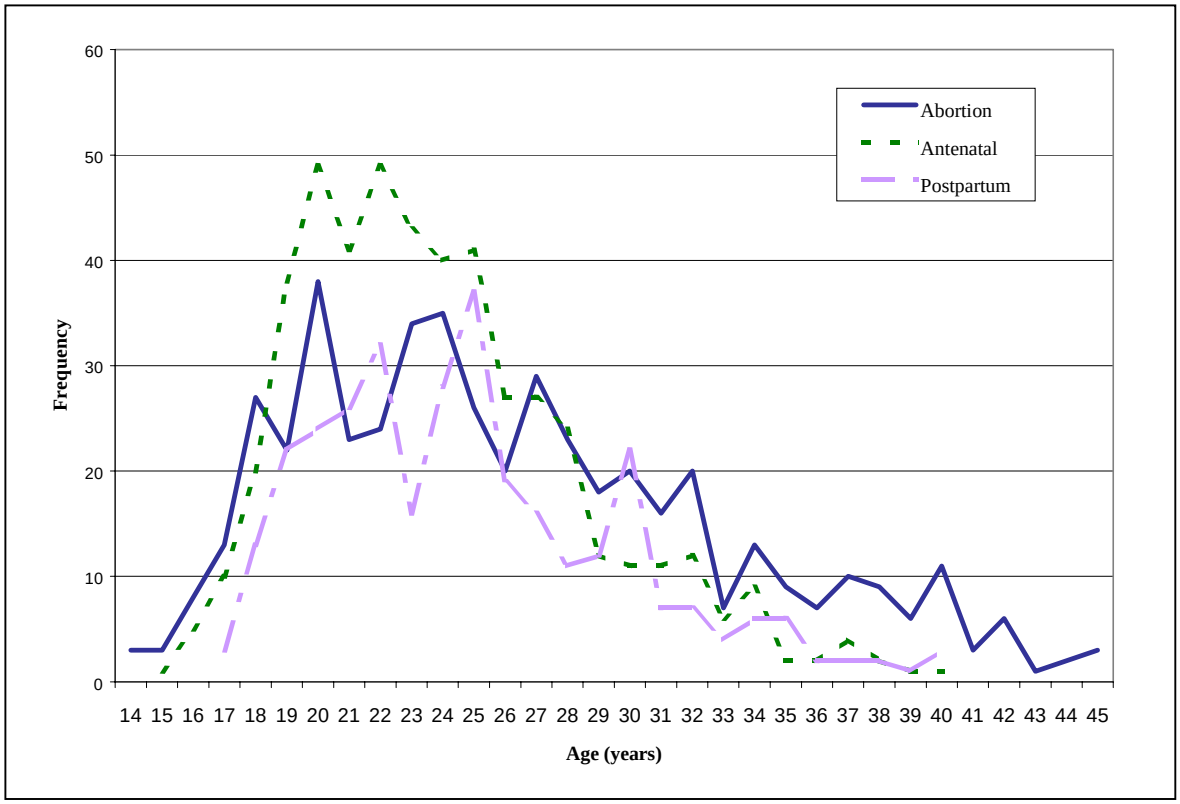
There was little difference in education among the different client types, but greater differences in their marital status. Not surprisingly, more abortion clients reported that they were not married (never married, or currently divorced, separated or widowed) than those coming for antenatal and delivery care. Three times as many abortion clients as antenatal or postpartum women were single (never married).

Table 3.5 Demographic profile of clients

	Percent of Clients		
	Antenatal	Postpartum	Abortion
City			
Veliky Novgorod	28.3	31.8	29.9
Perm	45.8	46.0	43.8
Berezniki	25.9	22.2	26.4
Age Distribution			
15–24*	60.3	50.6	47.0
25–34	36.7	43.5	39.3
35–45	3.1	6.9	13.7
Education			
Less than complete secondary	7.1	6.5	7.2
Completed secondary	32.0	37.3	35.2
Any higher post-secondary	60.9	56.2	57.7
Marital Status			
Married	60.7	69.8	49.1
In unregistered marriage	33.8	22.2	21.9
Single, never married	3.7	7.1	22.5
Divorced/separated/widowed	1.8	0.9	6.5
Total percent	100	100	100
Number of respondents	491	324	489

* Includes three 14-year old abortion clients.

Figure 3.1 Age distribution of clients



Fertility history and intentions

Clients coming for all three types of services were asked a series of questions about their fertility history and plans for future births. The data shown in Table 3.6 show that clients for the different types of service vary with respect to their fertility history. Abortion clients have, on average, one more pregnancy than postpartum clients and more than one additional pregnancy (1.3) than the average antenatal client. Antenatal clients were twice as likely to be in their first pregnancy than abortion clients. This is probably due in part to the fact that few women in these cities have more than two live births in their lifetime.

As we see in Figure 3.2 (data shown in Table 3.6), however, when we asked women about their abortion history, about three of every four clients (for each type of service) reported at least one abortion of a pregnancy prior to the current pregnancy (of second or higher order pregnancies). A surprisingly large proportion of abortion clients (63%) intends to have another child. These women appear to be using abortion as a means of controlling their fertility, not only to stop childbearing altogether, but also to delay the next birth. About one-quarter of antenatal and abortion clients, and a third of postpartum clients, report that they want no more children. Twice as many antenatal and postpartum clients as abortion clients report that they are undecided about wanting more children in future. Postpartum and antenatal clients report a desired wait of around four years before the next child, while abortion clients report a slightly shorter wait (3.6 years).

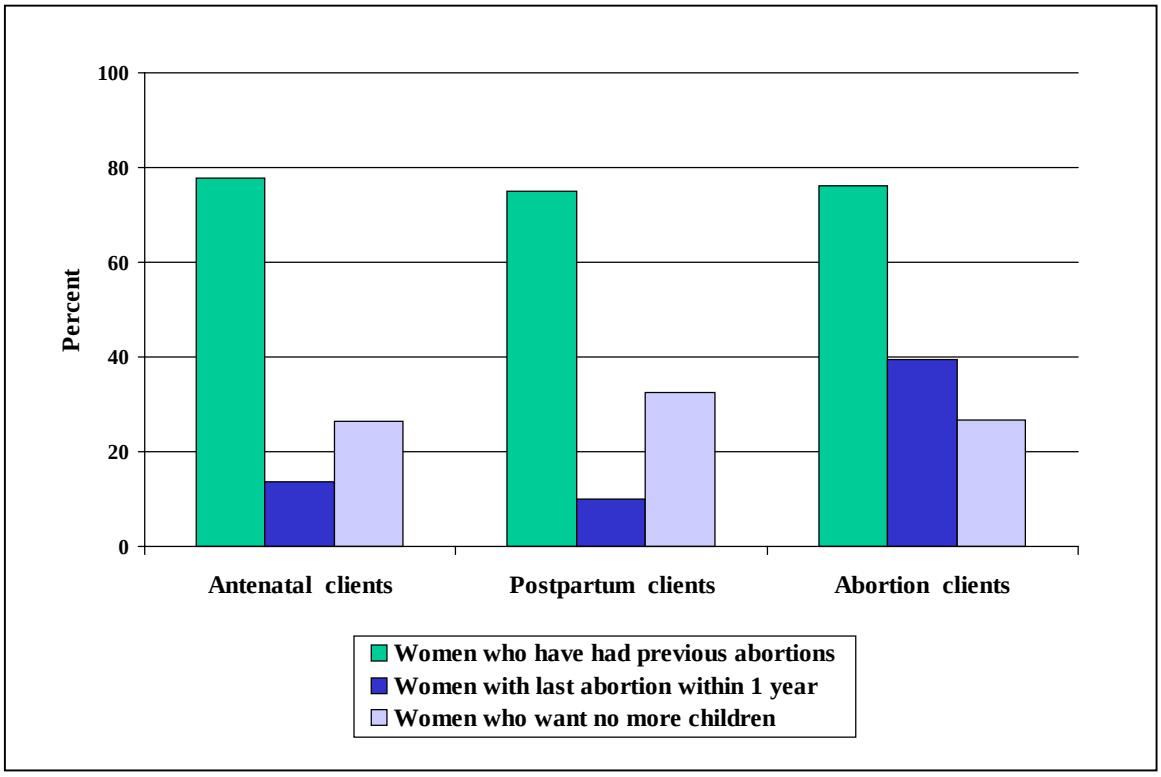
Table 3.6 Fertility history and intentions

	TYPE OF CLIENT		
	ANTENATAL	POSTPARTUM	ABORTION
Mean number of pregnancies (including current)	2.09	2.39	3.33
Percent first pregnancies	44.8	38.6	21.7
Number of living children+			
0	75.2	38.6	32.1
1	20.8	31.2	44.2
2	3.1	25.3	19.6
3+	1.0	4.9	4.1
Number of respondents	491	324	489
Percent of women who have had (previous) abortions, of those with more than one pregnancy	77.9	74.9	76.2
Number of respondents	271	199	383
Of those, the number of previous abortions			
1	60.7	54.4	41.8
2	23.2	22.8	30.8
3	16.2	22.8	27.4
Percent of women whose last abortion occurred within past one year	13.7	10.1	39.5
Number of respondents	211	149	291
Intention to have another child			
% yes	45.5	42.3	63.4
% want no more	26.3	32.4	26.6
% don't know	28.2	25.3	10.0
Mean desired wait until next, for those waiting	3.96	4.26	3.60

+ Excluding current birth, for postpartum clients.

Almost 40% of abortion clients in their second or higher-order pregnancy had terminated a pregnancy by abortion during the previous 12 months. More than 10% of antenatal and postpartum clients who had terminated a previous pregnancy by abortion also did so within the previous year.

Figure 3.2 Client abortion history and fertility intentions



Given the large proportion of women who have had repeated abortions, all three client types are clearly in need of more intensive counseling about contraceptive measures – during the antenatal period and post-delivery or post-abortion – than they currently receive (and see Chapter7).

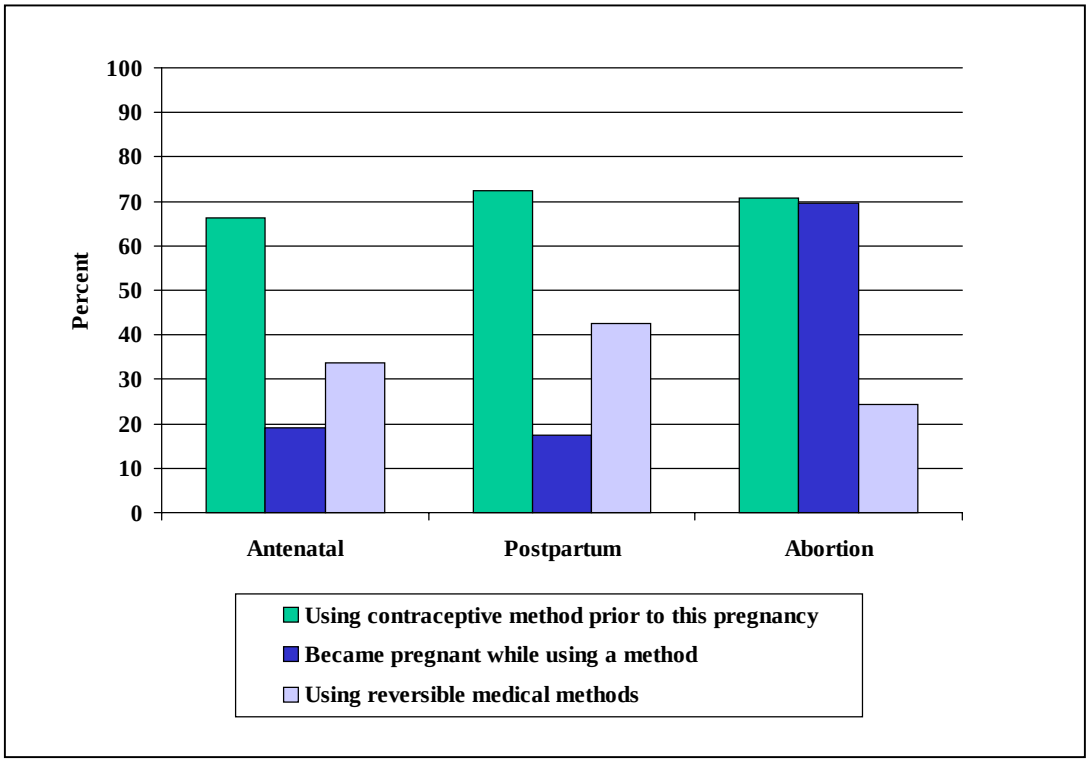
Contraceptive use among all clients

We also asked women if they had used a contraceptive method prior to their current pregnancy, and whether the pregnancy had occurred while using a method. The data displayed in Figure 3.3 show that antenatal clients were slightly less likely than postpartum or abortion clients to have used a contraceptive method. Thirty-four percent of antenatal clients were not using a method of contraception, as compared to about 28 percent of postpartum clients and 30 percent of abortion clients who had not used a method (Table 3.7 panel A).

Of the abortion clients who were using contraception, only about one quarter were using the more effective medical methods – pills, IUD, injections or implants (Table 3.7 panel B).. Almost half were using a barrier method (condoms, spermicides, diaphragms or cervical caps), more dependent on correct use, and nearly 30 percent were using traditional – and much less effective – methods (withdrawal, 'natural' family planning – rhythm).

As we can also see from Table 3.7 (panel C), about 80% of the antenatal and postpartum clients were not actually using a contraceptive method when they became pregnant. It seems that many were actively trying to become pregnant. Abortion clients, on the other hand, often reported that they were using a contraceptive method when the pregnancy occurred (70%).

Figure 3.3 Contraceptive use by different clients



Nearly three quarters of abortion clients who were using barrier methods became pregnant while using contraception. Between 50% and 95% of all clients who became pregnant while using a method were using traditional methods of birth control (Table 3.7 panel D).

Table 3.7 Contraceptive use by clients

		TYPE OF CLIENT		
		ANTENATAL	POSTPARTUM	ABORTION
A.	**Using contraceptive method prior to this pregnancy**			
	% using	66.2	72.5	70.6
	% not using	33.8	27.5	29.4
Number of respondents		491	324	489
B.	**Percent users by method type**			
	Medical	33.8	42.6	24.3
	Barrier	47.7	43.4	48.7
	Traditional	18.5	13.6	26.7
C.	**Percent who became pregnant while using a method**			
	% yes	19.1	17.4	69.6
	% no	80.9	82.6	30.4
D.	**Percent of users of each method type who became pregnant**			
	Medical	3.6	8.0	33.3
	Barrier	14.8	15.7	73.2
	Traditional	58.3	(53.1)	95.7
	Other	0.0	0.0	*

* Estimates based on less than 25 cases omitted. Estimates for cells based on 25-49 cases in ( ).

In each of the following chapters, we look at provider and client reports for the different types of health care: abortion services, delivery and postpartum care, and antenatal care. We look first at

practices as reported by providers of these services who were actively giving care in the three months prior to the survey, and then at the experiences reported by their clients. We cannot match these client reports to the practices of specific providers. Rather, as noted earlier, these reports present us with a picture of the knowledge, attitudes and practices of the *average* provider and the knowledge and experiences of the *average* client across all of the participating facilities.

Key WIN Indicators

76% of abortion clients who had more than one pregnancy were repeat abortion clients.
40% of repeat abortion clients terminated a pregnancy during the previous year.
79% of contraceptive users (all clients combined) report using modern methods (medical or barrier methods) prior to this pregnancy.
32.5% were using medical methods (oral, IUD, injections, implants, post-coital pill).

4. ABORTION CARE

Provider Abortion Care Practices

One hundred and three providers in our sample reported providing either abortion services or counseling for abortion clients. The data in Table 4.1 show that obstetricians and gynecologists are the only providers of regular and late-term abortions, and about 25% of these physicians report that they provide all types of services (mini-, regular and late-term abortion and counseling services). Only about 11% of these physicians report that they only perform mini-abortions (aspiration in the first six weeks of pregnancy).

About 17% of midwives who provide abortion care report that they perform or assist with mini-abortions, and 56% of midwives provide only counseling to abortion clients; the remainder reported providing both of these services to clients. In all, 75% of abortion care providers reported that they provide abortion counseling, either alone or in combination with performance of abortions.

Table 4.1 Type of abortion care provided

SERVICE PROVIDED	TYPE OF PROVIDER	
	DOCTOR	MIDWIFE
Mini-abortion only	11.3	16.7
All types	25.0	0
Counseling only	16.3	55.6

* Columns do not add to 100% because respondents could provide more than one type of service. The table does not include all possible combinations of responses.

We asked providers of abortion services if they themselves tell abortion clients what will happen during the procedure, and if they explain what is happening while performing the procedure. Eighty-seven percent of providers report that they give clients information prior to the actual procedure, but only 52% say that they also explain what is happening during the procedure (Table 4.2). (As we will see when we look at client experiences, most abortions are performed under general anesthesia.)

Most providers report giving pain medication when a patient experiences pain (83%), and 90% report informing clients about self-care after the abortion. However, less than half of these providers (47%) themselves see patients for a post-abortion check-up. The remaining providers either refer clients to another provider at the same facility where the abortion is performed (13%), or refer their clients to another facility for a post-abortion check-up (36%).

Table 4.2 Reported information given by abortion providers (N=103)

PROVIDER HIM/HERSELF GIVES:	YES (PERCENT)	NO (PERCENT)
Information to client before procedure	87.1	12.9
Information to client during procedure	51.6	48.4
Medication for pain	83.3	*13.5
Information to client about post-abortion self-care	90.0	**10.0
Sees patient for post-abortion check	46.6	
If no, refers to other provider at this facility	12.6	
If no, refers to provider at other facility	35.9	
Not applicable	3.9	
Missing	1.0	

* 3.1% give medication to some of their clients.

** Some of these providers say no one gives this information (1% of all abortion providers), and the rest say someone else gives this information.

Post-abortion contraceptive counseling reported by providers

One objective of the WIN Project is to improve the immediate availability of post-abortion contraceptive methods and counseling in these facilities. Almost all providers of abortion care (more than 90%) report that they currently discuss post-abortion contraceptive methods with their clients, as the data in Table 4.3 shows. The remaining providers say they refer their clients to someone else at the same facility to discuss post-abortion contraception.

Ninety-three percent of these providers also say that they themselves inform the woman (either before or after the procedure) about when she can again become pregnant. The 'correct' answer to the question varies, depending upon the type of abortion a woman receives. For mini-abortions and others performed within the first trimester of pregnancy, a woman is at risk of pregnancy as early as two weeks following an abortion. For second trimester abortions, she can become pregnant again within 4 weeks. Nevertheless, when asked when a woman can become pregnant post-abortion, only 53% of abortion providers in these facilities say "within 2 weeks", and more than 35% gave an incorrect answer to this question (see Table 4.3). Twelve percent of these providers gave another answer (not coded), and some may have referred to these differences.

Table 4.3 Post-abortion counseling reported by providers

	PROVIDERS (PERCENT)
Talks about contraceptive method at time of procedure	92.1
Informs the woman of when she can again become pregnant	93.1
Responses to the question "When can a woman become pregnant again:	
Correct (within 2 weeks)	52.6
Incorrect (after menses return, after 1 month)	35.8
Other	11.6

Abortion Client Experiences and Perceptions

First, we look more closely at the responses of abortion recipients regarding their fertility intentions. The data displayed in Figure 4.1 (and shown in Table 4.4) show that, while 63% of those who have just had an abortion plan to have a child at some future time, this varies markedly with the age of the client. Only half of the women between ages 25 and 34 definitely intend to

have a child in future (the largest number of 'undecided' women are in this age group), and less than 5% of women over age 35 intend to have another child.

Figure 4.1 Fertility desires of abortion clients by current age

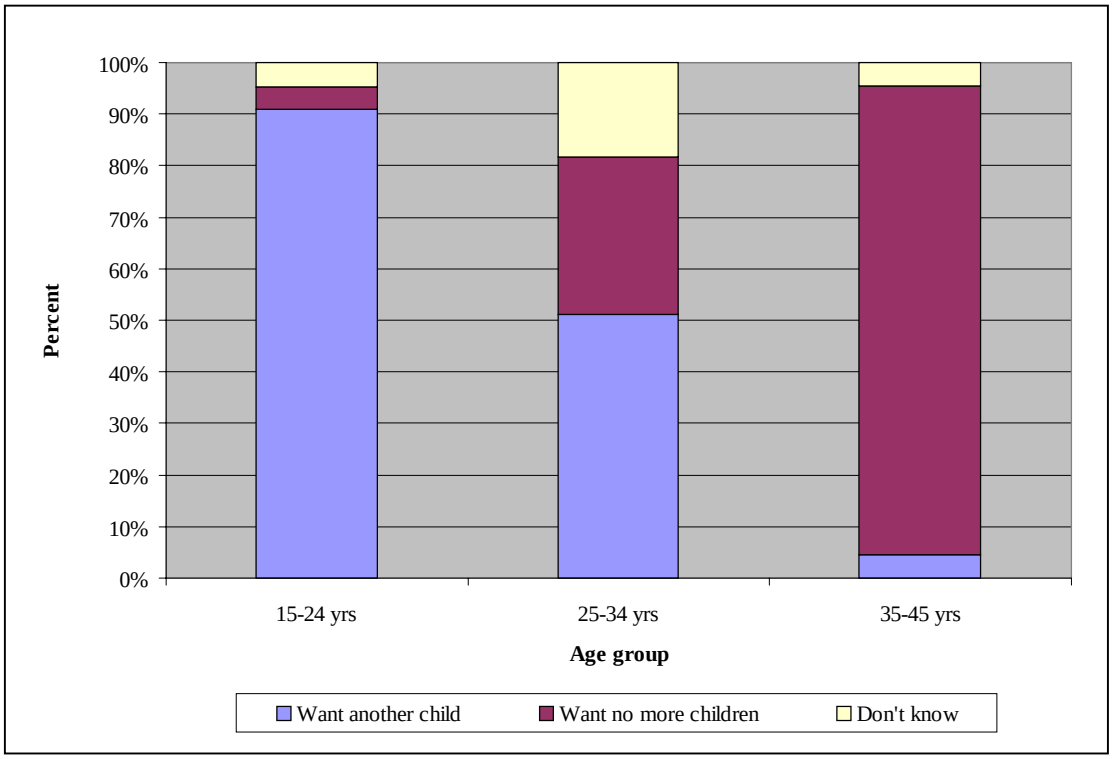


Table 4.4 Abortion clients planning to have a child in the future by age group

	10-YEARS AGE GROUP			TOTAL
	15–24*	25–34	35–45	
Yes	90.9	51.0	4.5	63.4
No	4.3	30.7	91.0	26.6
Don't know	4.8	18.2	4.5	10.0
Total	100.0	100.0	100.0	100.0
Number of respondents	230	192	67	489

* This group contains three 14 year-old clients.

In Chapter 3 we saw that 70% of abortion clients had used a contraceptive method prior to their pregnancy, and almost 70% of these women became pregnant while using a contraceptive method (a total of 240 women) (Table 3.7C). We now look at the specific types of contraceptives that abortion clients were using.

In the first column of Table 4.5 the distribution of all contraceptive users by type of method used is shown, and in the second column the distribution of users who became pregnant while using each method. In the last column, the percent of all users of the general category of method who became pregnant while using that type of contraceptive method is given.

We can see from Table 4.5 that 33% of those relying on medical reversible methods became pregnant while using these methods. Although the numbers are quite small, we see that almost half of those women using oral contraceptives conceived while using them, suggesting that they were using oral contraceptives inconsistently.

Almost three-quarters of those who were relying on the less effective barrier methods became pregnant while using the method; nearly 70% of women using condoms and almost 90% of those using spermicides became pregnant.

Of the smaller number of women relying on traditional methods of contraception, nearly all (96%) of these users became pregnant while using such a method. Almost 100% of the women relying on natural family planning (the 'rhythm' method) became pregnant, and nine out of ten women relying on withdrawal became pregnant.

Table 4.5 Distribution of last method used by whether pregnancy occurred while using the method

	% USERS USING EACH METHOD	% ALL USERS WHO CONCEIVED WHILE USING	% USERS OF METHOD TYPE WHO BECAME PREGNANT
Medical Reversible	N=84	N=28	33.3
Pills	10.1	(42.8)	
IUD	9.9	(20.5)	
Injection	0.9	(33.0)	
Post-coital pill	3.5	*	
Barrier	N=168	N=123	73.2
Condoms	36.2	68.8	
Spermicide/Creams/Jelly	12.5	86.0	
Traditional	N=93	N=89	95.7
LAM	0.5	*	
Natural Family Planning	16.5	98.2	
Withdrawal	9.6	(90.9)	
Other	0.3	*	
Total	100	69.6	69.6
Number of respondents	345	240	

* Estimates based on less than 25 cases omitted. Estimates based on 25-49 cases in ( ).

Most abortion clients were using a contraceptive method prior to getting pregnant, but 29% (144 clients) were not using any method (see Table 3.7A). These clients were asked why they were not using a method of pregnancy prevention (Table 4.6). Most women could or did not state a reason, but 12% said that the ease of obtaining an abortion was their reason, while 14% said that they had forgotten to use the method on that occasion. Thirteen percent of these women, who had just obtained an abortion, said that they had wanted to get pregnant, but for some reason when the pregnancy occurred, these women decided to terminate it.

Table 4.6 Reasons for not using a method

	PERCENT OF CLIENTS
Wanted to get pregnant	12.5
Had method, forgot to use	13.9
Too expensive	0.7
Could not obtain any method	6.3
Abortion easy to obtain	11.8
Other	20.8
Don't know/unsure	34.0
Number of respondents	144

We see from the data displayed in Table 4.7 that almost 70% of all abortions were conventional, induced abortions, and nearly 30% were mini-abortions (vacuum aspiration). Only 3% report having a late term abortion, that is, after twelve weeks of pregnancy.

Table 4.7 Distributions of abortions and reasons for obtaining abortion

	PERCENT OF CLIENTS
Type of Abortion	
Mini-abortion	28.6
Regular abortion	68.1
Late-term abortion	3.3
Reason for Abortion	
Not a good time	28.4
Dangerous to life/health	2.7
Risk of birth defect	6.7
Socioeconomic reasons	31.1
Do not have partner	2.7
Partner wanted abortion	4.1
Respondent did not want more children	18.0
Other	5.9
Don't know	0.4
Number or respondents	489

More than 30% of abortion clients said they had the abortion for 'socioeconomic reasons' and almost 30% stating that the time was not 'right' to have a baby (Table 4.7). It is difficult to draw firm conclusions about the underlying motivations of these women from such general statements as these. Another 18% of respondents replied that they did not want any more children.

Risk of birth defects or health reasons comprised another 9% of the reasons and 4% reported that their partner wanted the abortion. Some of the women who reported that they were not using contraception because they wanted to get pregnant may have obtained an abortion for these latter reasons.

Experience of abortion services

Women were asked what information they were given by medical staff, and how they were treated, before, during and after the procedure.

Table 4.8 Reports by abortion clients of experience of service Provided

	PERCENT
Doctor gave information, prior to the procedure, about what would happen during procedure	56.4
Doctor gave an opportunity to ask questions	81.2
During procedure, client was:	
Awake	14.1
Half awake	3.5
Asleep	82.4
Of those women not asleep	
Doctor explained what was happening during procedure	
Yes	57.0
No	43.0
Woman wanted to know what was happening	
Yes	47.7
No	52.3
Woman was comforted during the procedure	
Yes	86.0
No	14.0
Woman was given medication to ease the pain	
Yes	79.1
No	20.9
Number of respondents	86
Of all respondents	
Woman felt pain during the procedure	
Yes	13.3
No	86.7
Number of respondents	489

The reports of clients' experiences are displayed in Table 4.8. More than 40% of abortion clients (two out of every five clients) reported that the doctor did not tell her what would happen, and 20% said that they had no opportunity to ask the doctor questions before the procedure was carried out. This conflicts with reports by almost 90% of providers that they themselves give information about the procedure to clients prior to performing the abortion (see Table 4.2), suggesting that providers are inconsistent in providing such pre-procedure counseling.

The vast majority of clients, 82%, are asleep during the procedure. Since 30% of these clients received mini-abortions, this suggests that general anesthesia is used even for some of these simpler procedures. In fact, almost 80% of the mini-abortion recipients reported that they were asleep during the procedure (data not shown).

Of those who were awake, most reported that they were comforted by someone during the procedure (80%). Nevertheless, only 57% of these women were told by the doctor what was happening as the abortion proceeded, and almost half said they wanted to know. Fully 20% of these women were not given any pain medication.

We asked all women (awake and asleep) if they felt any pain during the procedure. Only 13% of the women reported feeling pain (Table 4.8), but 14 of these women said they felt pain despite being asleep during the procedure (data not shown).

Women were also asked about instructions for self-care following the abortion. 90% of providers said they themselves gave this information to abortion patients, yet less than 80% of clients report

receiving such information, and 15% report that they received no instructions about when to get a follow-up exam (Table 4.9).

Table 4.9 Information received by clients about after - care

	PERCENT
Told how to care for herself at home	
Yes	77.5
No	22.5
Told when to make a follow-up visit	
Yes	85.3
No	14.7
Number of respondents	489

Plans for post-abortion contraceptive use and contraceptive knowledge

All abortion clients were asked if they had been counseled about contraceptive use during their visit for the abortion, but only about 40% of clients reported receiving such counseling. Most of those who did receive counseling appeared to be satisfied, more than 95% reporting that the information was given respectfully, and that their questions were encouraged.

The major drawback, it seems, is that partners were not participants in the counseling: almost three-quarters of all abortion clients wanted their partners to participate in this counseling, too. Only eight clients reported that their partner accompanied them and participated in a counseling session on the day of the abortion.

Table 4.10 Post-abortion contraceptive counseling

	PERCENT
Medical staff talked about how to avoid another unplanned pregnancy (on day of abortion)	
Yes	41.1
No	58.9
Number of respondents	489
Pregnancy prevention information given:	
Respectfully	95.5
With indifference	3.5
Disrespectfully	1.0
Number of respondents	201
Questions encouraged	
Yes	94.5
No	5.5
Number of respondents	201
Client would like partner to participate in pregnancy prevention counseling*	
Yes	74.9
No	25.1
Number of respondents	455

* Excludes 8 women whose partner attended a counseling session that day and 26 women without a regular partner.

As the data in Table 4.11 show, when asked what method of pregnancy prevention they will use almost three-quarters of post-abortion clients say they have decided on a medical reversible method, and more than 90% name a modern method (medical reversible, sterilization or barrier

method). However, less than half of abortion clients have received professional advice about the method they have chosen, and almost 15% have not yet chosen a contraceptive method.

Table 4.11 Choice of contraceptive method for post-abortion clients

	PERCENT
Contraceptive Method	
Oral contraceptives	34.3
IUD	37.4
Injections or implants	2.6
Condoms	13.7
Spermicides, jelly or creams	3.4
Post-coital pill (emergency contraception)	1.2
Tubal ligation	3.1
Natural family planning	0.2
Condoms and spermicides or other combinations	1.2
Other	2.9
Total (Number of respondents)	100 (417)
Discussed use of this method with:	
Medical staff	47.8
No one	37.4
Not yet chosen a method	14.7

Key WIN Indicators

Proxy Indicators:

40% of repeat abortion clients (gravidity 2 or more) had an abortion within the previous calendar year

41% of post-abortion women received or were offered family planning counseling on the day of the abortion at the facility where the abortion took place.

More than 75% of abortion clients who know what method they will use post-abortion name a medical reversible method and more than 90% name a modern method – medical reversible, sterilization or barrier.

48% of women discussed use of their chosen method with a member of facility medical staff.

Of these women, 83% said that the person had clearly explained how the method works, described the possible side effects, and explained what to do in case of problems with the method (an indicator of the quality of counseling provided).

5. ANTENATAL CARE

Since some of the WIN Project training will focus on evidence-based antenatal care, the survey sought to obtain a great deal of detailed information about current antenatal provider knowledge and practices. The WIN Project aims to ensure that all providers know which interventions have proven value and which may be unnecessary or even harmful to a pregnant women and foetus.

Provider Antenatal Care Practices

Ninety-eight providers who currently give care for antenatal clients in women's consultation centers were interviewed (Table 5.1). Most were obstetricians. We interviewed only providers at centers where routine antenatal care is provided. These are the antenatal caregivers with whom the project will work, and we wanted to know about the kind of *routine* antenatal care given. The antenatal period is also the best time to start preparing women and their families for the experience of childbirth and to give information about infant care and feeding.

Table 5.1 Providers of ANC care in women's consultation by type of provider

	PERCENT YES
Obstetrician	65.3
Midwife	33.7
Other	1.0
Number of respondents	98

Antenatal care providers report that they routinely perform tests for anemia and syphilis and more than 9 out of 10 routinely screen women for 'high risk' pregnancies (Table 5.2 panel A). Even more (94%) report routinely ordering ultrasounds for their clients.

Among the items providers report prescribing for their clients in the previous three months are some that are potentially unnecessary, or without proven value, such as vaginal creams (usually prescribed by 76% of antenatal care providers), herbs (65%) and homeopathic medicines (12%) (Figure 5.1). Some may even be harmful if prescribed inappropriately, such as hormones (26%) and antibiotics (36%).

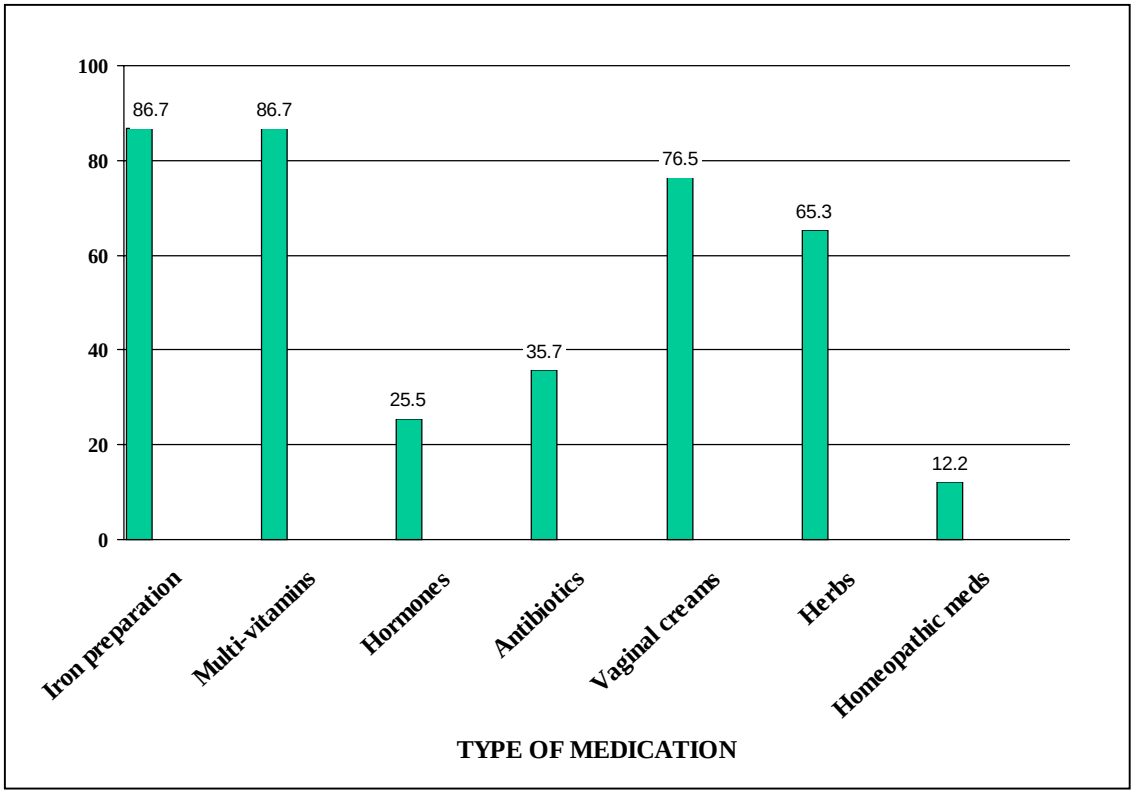
Current World Health Organization (WHO) guidelines state that anemic women should receive and consume daily iron folate supplements for at least 90 consecutive days during pregnancy[3]. The WIN Project is following these guidelines. Others suggest that where anemia prevalence is high (more than 40% prevalence) women should continue the dose for 3 months postpartum[4]. Yet, of the 87% of antenatal caregivers who say they usually prescribe an iron preparation for pregnant women, almost 40% prescribe it for less than one month and another 40% prescribe it for only a month (Table 5.2 panel B).

[3] World Health Organization Regional Office for Europe (1998) *Essential antenatal, perinatal and postpartum care.* Copenhagen: WHO Regional Office.
[4] Stoltzfus, RJ, Dreyfuss, M.L (1998), *Guidelines for the Use of Iron Supplements to Prevent and Treat Iron Deficiency Anemia,* cited in Elder, L. (2000) *Issues in Programming for Maternal Anemia,* Washington, DC: Mothercare.

Table 5.2 Antenatal care reported by providers

	PERCENT YES
A. Routine Care Practices	
Test for syphilis	94.9
Test for anemia	94.9
Screen for high risk pregnancies	90.8
Order ultrasound procedure	93.9
B. Usual Prescribing Practices	
Iron preparation	86.7
Of those prescribing iron, (N=84) duration for which provided:	
Less than 4 weeks	37.0
One month	39.0
Other answers	24.0
Number of respondents	98

Figure 5.1 Percent of antenatal care providers who usually prescribe various medications during pregnancy



Many caregivers appear to select which clients need to hear about specific topics. Almost 20% report that they discuss STDs and AIDS with only some of their clients and very few ask about or examine all women for signs of domestic abuse (Table 5.3). Evidence is now accumulating that domestic violence is a problem in these cities, as elsewhere in Russia[5]. Elsewhere, we report that between 17% and 24% of women of reproductive age have experienced threats or actual violent

[5] VCIOM, CDC, USAID *1999 Russia Women's Reproductive Health Survey: A follow-up of 3 sites, Preliminary Report: March 2000.*

acts committed by a partner[6]. More than 70% of antenatal providers we questioned say they do not ask any of their clients about domestic abuse or examine their clients for signs of injury.

More than 60% of antenatal caregivers say they discuss postpartum contraception with all their clients, and 78% report discussing with all clients warning signs of problems with a pregnancy, for which women should seek immediate medical attention (Table 5.3).

Table 5.3 Topics discussed with antenatal clients (Number of respondents = 98)

INFORMATION TOPICS	YES WITH ALL	YES WITH MOST	YES WITH SOME	NO
STDs, HIV or AIDS	54.1	22.4	18.5	5.1
Ask about/examine for domestic abuse	6.1	4.1	18.4	71.4
Postpartum contraception	62.2	15.3	10.2	12.2
Discuss warning signs for complications	77.6	10.2	11.2	1.0
Discuss warning signs for complications with partner/family	5.2	11.5	42.7	40.6

Very few providers (less than 15%) report that they discuss warning signs for complications of pregnancy with most or all women's partners or other family members, and two out of five providers say they never discuss these signs with family members.

We also wanted to know which signs these providers mentioned when advising women when to seek immediate medical attention. There is general international agreement that women should be counseled to seek immediate medical care for the following danger signs that may occur during pregnancy:

- bleeding,
- acute abdominal pain,
- fever,
- premature rupture of membranes,
- headaches and/or blurred vision,
- swollen face or hands,
- vaginal discharge/itching or pain on urination, and
- reduced fetal movements.

While recommending women take action for other signs is not harmful, the providers who do counsel their clients about danger signs do not uniformly mention all of these, as the data in Table 5.4 indicate, and none of these signs were mentioned by all providers. Only 30% of all providers advise women to seek care for swollen face and hands (a warning sign for pre-eclampsia) or reduced fetal movements (possible fetal compromise), and less than 20% mention fever (possible infection).

[6] David, *et al*, (2000) *Women and Infant Health Project Household Survey 2000: Report of Main Findings*, Boston: John Snow, Inc., December.

Table 5.4 Signs for which women are advised to seek care

	PERCENT YES
Bleeding	91.8
Acute/constant abdominal pain	89.8
Headaches or blurred vision	76.5
Fever	18.4
Premature rupture of membranes	52.0
Premature labor	35.7
Burning with urination	8.2
Vaginal itching/foul odor	9.2
Swollen face/hands	30.6
Swollen legs	41.8
Reduced fetal movements	31.6
Other	13.3
Number of respondents	98

Almost all antenatal care providers reported using a risk screening tool to classify pregnancies as normal or 'high risk'. Women who receive a high-risk classification are often very restricted in their choices for delivery care (e.g. may not be allowed rooming-in or immediate breastfeeding or visitors). They may also be hospitalized for some period prior to delivery. In an open-ended question, we asked providers what were their usual reasons for labeling a pregnancy as high risk. We obtained a very long list of conditions. The twenty or so most frequently cited reasons were coded and entered into the computer; the remaining 32% of responses were coded only as 'other'.

Providers (who could mention up to five different conditions) mentioned the conditions shown in Table 5.5 most frequently. Some of these diagnoses are not frequently encountered outside Russia, and require further explanation. Gestosis, for example, refers to a variety of hypertensive disorders of pregnancy, including pregnancy-induced hypertension and pre-eclampsia.[7] 'Extra-genital pathology' refers to non-pregnancy related health problems, and was the most-frequently cited reason for classifying a pregnancy as 'high-risk'. Other reasons, such as history of stillbirth or infant death, which might be more often cited by specialists in other countries, were mentioned by less than 10% of these caregivers. One condition frequently cited is a history of abortions (28% of responses), either spontaneous or induced, but we have already seen that about 75% of antenatal clients have a history of induced abortions.

Table 5.5 Reasons for classifying a pregnancy as high risk

REASONS MENTIONED BY MORE THAN 10% OF PROVIDERS:	PERCENT YES
Extra-genital pathology*	55.1
Renal diseases	12.2
Anemia	11.2
History of obstetrical complications	32.7
History of abortions	28.6
Uterine scars (previous Cesarean section)	26.5
Gestosis*	11.2
Number of respondents	98

* See text.

[7] Pauline Glatleider, consultant midwife, personal communication.

Breast-feeding knowledge and advice

Another focus of the WIN Project training for providers (as well as IEC messages for clients) is breast-feeding advice, and the advantages and practice of exclusive breastfeeding. We asked antenatal caregivers to list what they recommended their clients to feed babies for their first six months. 90% of providers responded to this question, but only 46.9 % of antenatal caregivers gave answers that are in keeping with the definition of 'exclusive breastfeeding' – giving only breast milk and nothing else (except vitamins or mineral supplements) for the first six months.

We also asked what these providers usually recommend to their antenatal clients when discussing preparations for delivery and in the postpartum period. The data in Table 5.6 show that more than 75% of all providers say they recommend clients to breastfeed their babies 'on demand' and less than 20% recommend a set schedule for breastfeeding. A large proportion of providers, 70%, say they recommend that the baby should stay in the mother's room at all times ('rooming-in'), rather than in a nursery.

Almost all providers (91%) report recommending that a woman participate in her own care, but this response provides a great deal of room for individual interpretation, and does not necessarily reflect the WIN Project's own definition of 'participation':

> Participation is a woman making informed decisions and choices regarding aspects of care related to her pregnancy, her well-being and the well-being of her fetus. Her active participation and that of her family is enabled and enhanced when a provider … places the woman and family at the center of care and collaborates with a woman and her family in designing a plan of care to meet their specific needs and preferences.

Only about half of these providers recommend that women and their partners have some type of joint preparation for the childbirth experience. Even fewer, about 40%, recommend to their clients to have a family member present during the birth.

Table 5.6 Usual recommendations to antenatal clients

	PERCENT OF PROVIDERS
Rooming-in	70.4
Breastfeeding on demand	76.5
Scheduled breastfeeds	19.4
Partner or family member present at birth	38.8
Woman's participation in her own care	90.8
Childbirth preparation together (woman and partner)	51.0
Total number of antenatal care providers	98

Key WIN Indicator

% of providers who can correctly define 'exclusive breastfeeding'

Proxy Indicators:

74 % of providers say they discuss exclusive breastfeeding with their antenatal clients.

47 % say they recommend giving only breast milk and nothing else (except vitamin and mineral supplements or medicine) for the first 6 months.

Antenatal client experiences and perceptions

Interviews were conducted with a total of 491 antenatal clients, most of whom (84%) began their visits for antenatal care in the first trimester of pregnancy (Table 5.7). Timing of first visit varied slightly by city of residence: slightly fewer women in Berezniki began their care in the first trimester (74%), while 90% in Veliky Novgorod and 85% in Perm began their care in the first trimester (data not shown).

As we see in Table 5.7, most of our respondents are in their third trimester of pregnancy. Because women come for care much more frequently in the third trimester (usually weekly), on any given day our interviewers were more likely to encounter a woman in her 3rd trimester than one who was in an earlier stage of her pregnancy. Most of our respondents have nearly completed their antenatal care.

Table 5.7 Trimester of first and current antenatal visit

	PERCENT OF CLIENTS
Trimester of first antenatal visit	
First	83.7
Second	14.5
Third	1.8
Trimester of pregnancy (current visit)	
First	5.3
Second	21.2
Third	73.5
Number of respondents	491

Contraceptive use and fertility intentions

Before we examine women's reports of the antenatal care they receive, we look more closely at the women who reported becoming pregnant while using a contraceptive method. As we saw in Chapter 3, only 66% of antenatal clients reported that they were using a contraceptive method before they became pregnant (Table 3.7). Of former users, even fewer (19%) became pregnant while actually using the method. Table 5.8 displays more detailed information about the methods these women were using at the time pregnancy occurred.

Apart from the lower proportion of users who became pregnant while using a method, there were few noticeable differences in choice of methods between antenatal clients and abortion clients (compare with Table 4.5). Like abortion clients, a large proportion of antenatal clients had been using barrier methods of birth control. However, only about 15% of users of barrier methods were actually using the method when the pregnancy occurred. In contrast, nearly 60% of the small number of antenatal clients using traditional methods conceived while using the method.

Table 5.8 Antenatal clients: Distribution of last method used by whether pregnancy occurred while using the method (N=Number of users)

	TOTAL % OF ALL USERS USING EACH METHOD	% OF USERS OF EACH METHOD WHO BECAME PREGNANT	% OF USERS OF METHOD TYPE WHO BECAME PREGNANT
Medical Reversible	N= 110	N=4	3.6
Pills	22.5	2.7	
IUD	9.8	(6.3)	
Injection	0.9	0	
Post-coital pill	0.6	0	
Barrier	N=155	N=23	14.8
Condoms	41.8	12.5	
Spermicide/Creams/Jelly	5.8	**6	
Traditional	N=60	N=35	58.3
LAM	0	0	
Natural Family Planning	11.1	(52.8)	
Withdrawal	7.4	*	
Other	0	0	
Total	100	19.1	19.1
Total number of respondents	325	62	

* Estimates based on fewer than 25 cases omitted. Estimates based on 25-49 cases in ( ).

Those clients who said they had not used a method before the pregnancy occurred were asked their reasons for non-use (Table 5.9). Most women wanted to get pregnant (65%), while about a quarter said they were unsure of their reason for not using contraception.

Table 5.9 Reasons for not using a method

	PERCENT CLIENTS
Wanted to get pregnant	65.1
Had method, forgot to use	0
Too expensive	1.8
Could not obtain any method	1.2
Abortion easy to obtain	1.8
Other	6.0
Don't know/unsure	24.7
Number of respondents	166

Antenatal clients were also asked how long they wanted to wait between the birth of this child and the next child. The data in Table 5.10 show the distribution of responses by age of the woman. The most striking finding, perhaps, is that few women of any age – only 17% of the total – want to wait for three years or less between births. Only 16% of the youngest women and 19% of women 25 to 34 years old want to wait this long. Almost 40% of the youngest women said they want to wait more than 3 years before their next birth. And 14% of these young women want no more children; 43% of women 25-34 also want no more children. Only six women reported wanting to have another child immediately (with one year), and 5% want to wait only two years (data not shown).

These responses clearly highlight the importance of contraceptive counseling for women during the period leading up to their birth.

Table 5.10 Future pregnancy intentions by age group

	10-year Age Group			Total
	15–24	25–34	35–45	
Wait 3 years or less	15.8	18.8	0	16.5
Wait more than 3 years	38.5	14.8	*1	29.0
Want no more children	14.4	43.2	*8	26.3
Don't know	31.3	23.3	*3	28.2
Total	100.0	100.0	100.0	100.0
Number of respondents	291	176	12	489

* Estimates based on less than 25 cases omitted.

Care received in the antenatal period

Antenatal clients were asked to report in some detail what care they had received during this pregnancy, including procedures they were subjected to, and medications they were instructed to take.

Ultrasound technology is used more frequently in Russia than in some other countries. Women who are in the first trimester of pregnancy are exposed for less time to the chance of multiple ultrasound procedures. The data in Table 5.11 show that 92 %of clients were given at least one ultrasound during the antenatal period. The second panel of Table 5.11 shows the distribution of numbers of ultrasound procedures women experienced by the current stage of their pregnancies. By the third trimester, almost 75% of women had 2 or more ultrasound procedures, and 37% were given 3 or more ultrasounds.

Table 5.11 Ultrasound procedures experienced by antenatal clients

	PERCENT OF CLIENTS (N=491)		
Ultrasound this pregnancy			91.9
Distribution of ultrasounds by trimester of pregnancy	**1st**	**2nd**	**3rd**
0	(53.8)	19.2	1.7
1	(46.2)	61.5	23.8
2	0	16.3	38.0
3+	0	2.9	36.6
Number of respondents	26	104	361
Told reason for ultrasound			67.6
Distribution of reasons for ultrasounds			
Status of fetal development			59.7
Examination for the term of gestation			27.2
Examination for fetal developmental defects			17.7
Risk of loss of a pregnancy			5.6
Examination for fetal position			7.2
Examination for excessive amniotic fluid			5.6
Examination for placental localization			5.6
Determination of the number of fetuses			1.3
Checking if the umbilical cord is winding			0.3
Other			13.1
Number of respondents			305

Estimates based on 25-49 cases in ( ).

Despite the frequency of these procedures, only 68% of antenatal clients reported that they were told the reason for an ultrasound procedure. The distribution of those reasons is shown in the bottom panel of Table 5.11. These data suggest that many procedures are carried out to assess

fetal development, and may be done repeatedly. Sixty percent of women who were given a reason for the procedure were given this reason.

More than 80% (four out of every five women) were given a prescription for some kind of medication during their pregnancy, and 95% of those women (77% of all antenatal clients) said they had received a prescription for multi-vitamins (Table 5.12). Less than half of all antenatal clients (47.7%) reported getting a prescription for an iron preparation. Only 86% of women who received a prescription for any medication reported actually taking all of the prescribed medications. A similar proportion of respondents who were given a prescription (85%) was told the reason for the medications.

Table 5.12 Experience of services provided

	PERCENT YES RESPONSES
Given any prescription for medication during this pregnancy	80.9
Given iron preparation	47.7
Given multi-vitamins	76.8
Given others	54.4
Told reason for that medication (N= 397)	84.9
Took the medication	86.1
Received information on:	
STDs, HIV, AIDS	17.3
Alcohol and cigarettes	48.1
Drugs	32.6
Nutrition during pregnancy	82.3
Physical and emotional changes during pregnancy	44.0
Partner/family participation support during childbirth	20.8
Option to have baby with her day and night	15.5
Any of these topics discussed with partner/family members	5.7
Number of respondents	491

We asked antenatal clients what topics the medical staff had discussed with them on any of their antenatal visits. The data displayed in the second panel of Table 5.12 show that nutrition during pregnancy is the topic most likely to be discussed by providers (82% of women report receiving information about nutrition), followed by alcohol use and smoking (48%) and changes expected during the pregnancy (44%).

In the previous section, we saw that more than half of all providers said they discussed STDs, HIV and AIDS with pregnant clients (Table 5.3), but only 17% of women report receiving information about that subject (Table 5.12). Considering the importance of smoking during pregnancy, drug use, and risks associated with sexually transmitted diseases, these appear to be neglected topics for discussion with pregnant women.

Partner support during childbirth and the option to have 'rooming-in' with baby were discussed with fewer than 1 in 5 pregnant women, compared with provider reports that almost 40% discussed partner support at birth and 70% discussed 'rooming-in'. (Compare with Table 5.6.) Only 6% of women report that any of these topics were discussed with her partner or another family member either individually or in childbirth preparation classes.

Of course, none of these women had completed their antenatal care, but 75% were in their 3rd trimester. These subjects should be discussed early enough in the pregnancy to allow women to

make changes in their behavior, or to arrange for someone to be present – and learn how to support them – at their delivery.

Explanation of danger signs – women's reports

An important part of good antenatal care is ensuring that the woman understands the signs that indicate serious complications, for which she should seek immediate medical attention. Only 75% of these antenatal clients reported hearing such information. This is consistent with information reported by providers; about 78% of providers report telling all their clients about warning signs (Table 5.3). More women remember the doctor mentioning headaches and blurred vision (88%) and bleeding or spotting (74%) than any other signs. Only about 15-17% of clients recalled that fever, abdominal pain, or premature rupture of the membranes were danger signs. Far fewer recalled hearing that swollen face and hands or reduced fetal movements were danger signs (8% and 9%, respectively).

Only 7% of clients reported that the doctor also gave information on any danger signs to the client's partner or her family. This is also consistent with reports from providers; only 5% of providers said that they discussed the warning signs with all families (Table 5.3).

Table 5.13 Explanation of danger signs

	PERCENT OF CLIENTS
Doctor discussed danger signs requiring immediate medical attention	73.7
Number of respondents	491
Signs doctor mentioned to client	
Bleeding or spotting	73.5
Headaches or blurred vision	88.1
Abdominal pain	14.9
Fever	14.4
Premature rupture of membranes	16.9
Premature labor	16.9
Vaginal itching or foul odor	3.0
Swollen face or hands	7.5
Reduced fetal movements	8.6
Other	11.6
Don't know	0.8
Number of respondents	362
Doctor gave this information to client's partner/family	7.1

Antenatal clients were asked if they would like to have a close person present for support during labor and birth. As the data in Table 5.14 show, many women are reluctant to have anyone other than medical staff present during their labor and delivery. Almost half of all the youngest women and more than 60% of older women said they wanted no one with them for support during the birth. However, younger women were more likely than older women to say they wanted the baby's father to be present to support them (35% as compared to 29%).

This idea is clearly very new to these women, and in any case, until recently has not been an option.

Table 5.14 Percent of women wanting various persons for support during childbirth by age group

	AGE GROUP			TOTAL
	15–24	25–34	35–45	
Baby's father	34.5	28.9	*	32.0
Other family member	7.8	3.3		5.9
Female friend	.3	1.1		0.6
No one	48.6	60.0	*	53.4
Don't know	8.8	6.7	*	8.1
Number of respondents	296	180	15	491

* Estimates based on less than 25 cases omitted.

Preparation for the postpartum period

Antenatal clients were asked if anyone had discussed exclusive breastfeeding, care of the newborn or self-care after the birth during antenatal visits. Clients reported that these important topics, preparing women for the postpartum period, were infrequently discussed by antenatal caregivers (Table 5.15). Less than 25% of women reported discussing exclusive breastfeeding, less than 20% discussed care of the newborn, and only 16% had heard postpartum self-care discussed. (Almost 75% of antenatal care providers say they discuss exclusive breastfeeding with their clients.)

Those clients who had discussed exclusive breastfeeding with their provider during antenatal care varied considerably by city (data not shown). Almost 34% of clients in Perm had been told about this at some time during their antenatal care, compared with only 22% of clients in Veliky Novgorod and 13% in Berezniki.

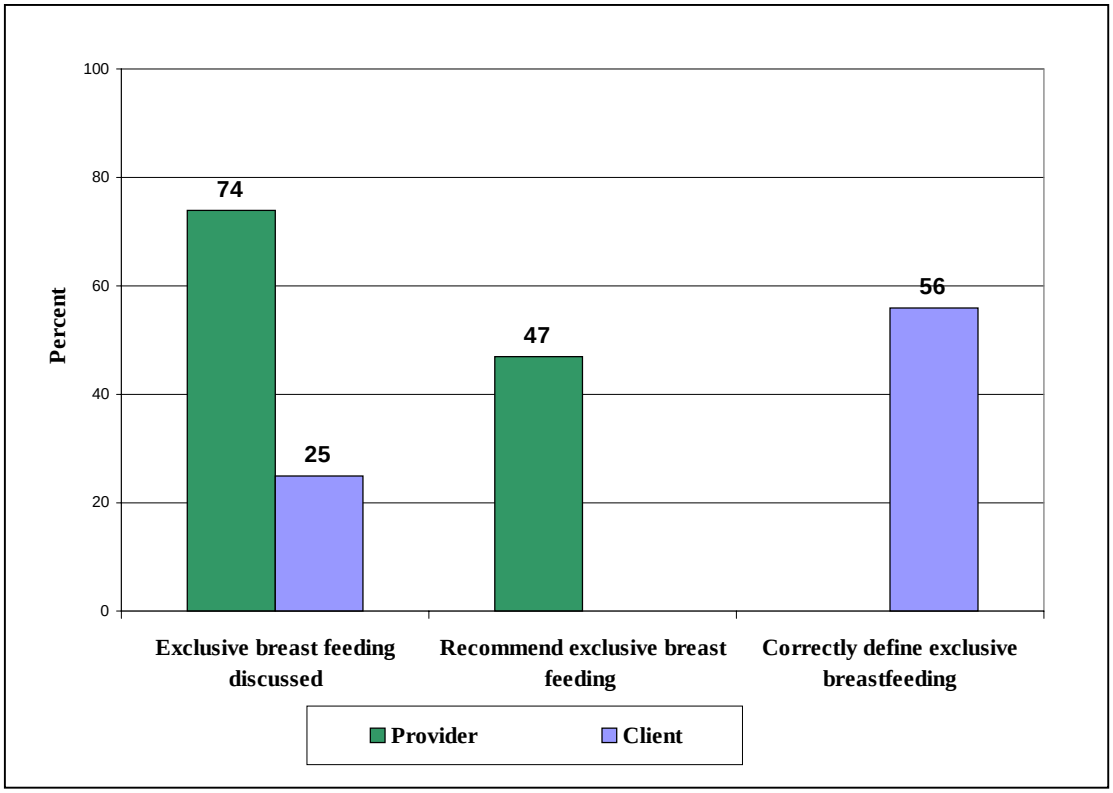
Table 5.15 Topics clients reported discussing in antenatal visits

INFORMATION TOPIC:	PERCENT YES RESPONSES
Exclusive breastfeeding	25.1
Care of your newborn	18.1
Care of yourself after delivery	15.9
Number of respondents	491

Despite the apparently low level of information about exclusive breastfeeding provided to antenatal clients, some women are getting the 'message'. Fifty-six percent of all antenatal clients were able to correctly define the term 'exclusive breastfeeding' (giving breast milk and nothing else except vitamins, minerals, or medicine). This knowledge varied somewhat by city of residence: only 32% of antenatal clients in Veliky Novgorod gave the 'correct' definition, but 68% of women in Perm and 59% in Berezniki were able to describe the internationally accepted definition. Discrepancies between what antenatal clients report and what their caregivers report are shown in Figure 5.2.

It seems that women are getting information about exclusive breastfeeding from some channels other than their antenatal caregivers. Furthermore, fewer than half of antenatal providers recommend this option for the first six months of infancy.

Figure 5.2 Reported counseling about breastfeeding during antenatal care



Almost all clients report that they are planning to breastfeed their baby (99%). Only 1% (n=6) had been advised not to breastfeed, and a similar number had been instructed how to use infant formula for feeding.

It is important for the project to identify those providers most likely to be consulted about breastfeeding to provide them with training so they are knowledgeable about current recommendations, and relay this advice to women. We asked antenatal clients who was the best person to consult if they had questions about breastfeeding, or needed advice. Almost 50% of women said the best person to consult is a neonatologist or pediatrician (Table 5.16). A further 20% said an obstetrician was the best source of advice, followed by about 22% who thought a family member was best.

Table 5.16 Antenatal clients opinions on sources of breastfeeding advice

BEST PERSON TO CONSULT ABOUT BREASTFEEDING	PERCENT OF CLIENTS
Obstetrician	19.8
Neonatologist/pediatrician	47.9
Midwife	2.0
Nurse	2.0
Friend	2.0
Family member	22.0
Other	2.2
Don't know	2.0
Number of respondents	491

Key WIN Indicator

56.0% of antenatal clients can correctly define 'exclusive breastfeeding'

Contraceptive knowledge and plans for contraceptive use

Another aim of the WIN Project is to increase the number of women who are aware of and use the lactational amenorrhea method (LAM) of contraception in the early postpartum period. LAM is an effective and safe method of contraception for the first 6 months of infancy if the mother exclusively breast-feeds on demand (day and night), and if her menses have not returned. The data in Table 5.17 show that at present most women do not believe that exclusive breastfeeding can be used as a contraceptive method, and only seven of those who did could correctly list all of the conditions under which it is effective. Only 6% of women (31 in all) reported that a provider had discussed the LAM method with them, and more than 75% of these women attended facilities in Perm. Nevertheless, even in Perm, these women accounted for only 11% of all antenatal clients.

Table 5.17 Women's beliefs about breastfeeding as contraception

	PERCENT OF CLIENTS
Think breastfeeding can be used as contraception	9.8
Know all 3 correct conditions when it is effective	(14.6)
LAM was discussed	6.3
Number of respondents	491

Estimate based on 25-49 cases in ( ).

Women were also asked what method of contraception they were planning to use after the birth. Of the more than 80% who planned to use a method, almost 60% named a medical reversible method of birth control (pills, IUD, injection/implant, post-coital pill). Only 6 antenatal clients said that they were planning to use LAM (1.5% of those planning to use any method).

Table 5.18 Postpartum contraception

	PERCENT OF CLIENTS
Planning to use a contraceptive postpartum	82.7
Number of respondents	491
Distribution of Methods (N=406)	
Medical	58.1
Barriers	15.5
Traditional	5.2
Sterilization	2.2
Other	19.0
When are you planning to start using that method	
Immediately after the birth	15.0
After a follow-up visit	26.8
After my menses return	6.8
When sexual relations start	19.0
Other	22.0
Not sure	10.5

Few of these women said they planned to start using the method immediately. Although timing depends upon which method a woman chooses, many are not sure when to begin using, or will

delay use until they have a postpartum check-up, which means they may be at risk of conception before they begin to use contraception. Women who plan to breastfeed also need to discuss appropriate contraceptive methods (that do not harm the infant or interfere with breast milk production).

6. DELIVERY AND POSTPARTUM CARE FOR WOMEN

Providers of Maternity and Neonatal Care

We questioned medical staff in maternities who said they provide care for mothers during delivery and postpartum, and those who provide care for neonates and advice about newborns to mothers in maternities. We wanted to establish the 'usual' practices in participating facilities, as well as knowledge and attitudes held by these staff about breastfeeding and other subjects. We also included neonatologists and pediatricians who work in children's polyclinics when examining provider knowledge and attitudes, since these specialists are responsible for much of the counseling women receive about infant feeding.

Table 6.1 shows the distribution of medical staff interviewed about delivery care and care for neonates.

Table 6.1 Number of providers of different service, by specialty and type of facility

SERVICE PROVIDED	SPECIALTY OF PROVIDER				
	OBSTETRICIAN / GYNECOLOGIST	NEONATOLOGIST/ PEDIATRICIAN	MIDWIFE	CHILDREN'S NURSE	TOTAL N
In Maternity:	70	1	50		121
Care for mothers					
Care for neonates	22	37	27	35	121
Care for neonates in polyclinic		95		43	138

Provider Practices

Restriction to the lying in bed during labor is now known to extend the duration of labor, on average, and may adversely affect the condition of the fetus and the progress of labor. Other practices that may be unnecessary or of unproven effectiveness were also investigated. We asked delivery caregivers what restrictions they impose on their patients during labor and delivery.

Delivery/Postpartum Care for Mothers

While physicians are allowed to exercise their clinical judgement to some degree, most maternity hospitals have strict procedural guidelines for care. Delivery care providers were asked to report what routine preparations for delivery and care during normal labor and delivery were followed in their facilities. The question was phrased to allow providers to indicate those procedures that are applied to virtually all women as well as those carried out on the basis of provider judgment (i.e. only when indicated). In Table 6.2 their responses are displayed.

Perineal shaves are nearly universal, with enemas and pain relief medication also very prevalent (78% and 61% of providers, respectively, report these procedures are routine for all women). Pain relief medication is reported to be routine for all patients by more than 75% of providers (in all facilities) in Veliky Novgorod and Berezniki, but only 30% of providers in one maternity in Perm. About half of providers in the other Perm maternity say that this is standard for all patients.

Almost 40% of providers say they restrict oral fluids for women in labor, and less than 10% say this is not a routine practice for any women in their facility. More than 30% of providers also report that women are not allowed to assume a sitting position during labor or delivery. This practice seems to vary considerably across participating facilities (data not shown). In one Veliky

Novgorod facility, most providers report that all women are allowed to assume the sitting position, while in the other facility, about half of providers say that this is not allowed for any patient. In Berezniki more than half of the providers say that all women can do so and no provider in Berezniki says that this is not allowed for any patient. In both maternities in Perm, about half of providers report that the sitting position is not allowed for any patient.

More than 40% of delivery caregivers report that the partogram, a method of monitoring progress during labor, is not used at all in their facility. Only 30% of providers say that the partogram is used routinely for all women[8]. (While the total number of providers is quite small, we can see that almost all providers in Berezniki say the partogram is not used at all in their facility. This contrasts with Veliky Novgorod and Perm, where about 40% of providers say that the partogram is used routinely for all women.)

Table 6.2 Percent of providers reporting usual practices in maternity care

	PERCENT OF PROVIDERS		
	YES	ONLY FOR SOME WOMEN	NO
Perineal shave	96.7	3.3	-
Axillary shave	52.1	19.0	28.9
Enema	77.7	22.3	-
IV solution	35.5	64.5	-
Medicine to induce labor	1.7	96.7	-
Medicine for pain relief	61.2	38.8	-
Restricted to bed rest	3.3	81.8	14.0
Artificial rupture of membranes	1.7	98.3	-
Restrict foods	19.8	61.2	18.2
Restrict oral fluids	38.8	50.4	9.9
Episiotomy	0.8	98.3	-
Monitor labor with special equipment (electronic monitors)	9.9	81.8	7.4
Monitor labor with partogram	32.2	25.6	41.3
Allow women to walk	57.0	40.5	1.7
Allow women to sit up	43.0	25.6	30.6
Allow close person to be present during birth	26.4	71.1	0.8
Number of respondents	121	121	121

Classification of 'high risk' women

Some of the above procedures are aimed specifically at women whose pregnancy is designated as 'high risk' in terms of expected complications for either mother or neonate. Some, such as allowing a family member to be present, or ambulation during labor, are not permitted for 'high risk' cases. We examined the number of providers who had responsibility for any postpartum women. (Due to the low birth rate, more than 40% of these providers said they had no postpartum women in their care on the day of interview). Of the remaining 71 providers, 63% said that they had women designated as 'high risk' in their care. (See Table 5.5 for conditions antenatal caregivers frequently use to designate high-risk pregnancies.)

[8] The partogram in use does not meet the criteria of the standard WHO partogram (personal communication, Pauline Glatleider, consultant midwife).

Neonatal care practices at time of delivery

When the baby is born, a number of procedures are carried out; some of these practices have been shown to improve the outcome or the subsequent care of newborns, while the value of others is unproven or potentially harmful. Tight swaddling, for example, is now discouraged, as is routine suctioning with a catheter[9] and bathing or cleaning the baby with oil should be postponed until 2 to 6 hours after birth, and only when the newborn's temperature is stable[10]. In regions where gonorrhea is prevalent, prophylactic eye treatment is recommended as routine practice, but there is no evidence that prophylactic treatment of the newborn's genitals is beneficial.

Reports from providers responsible for care of the newborn in maternities show that some of these practices are very widespread for all newborns (Table 6.3). These include swaddling the infant (86% do this for all neonates), weighing the baby (87%), and prophylactic treatment for eyes or (in the case of females also) genitals (81% and 73% respectively). A surprising 10% of providers report that none of the newborns in their facility are weighed, a procedure that should be performed within one to two hours after birth to provide a baseline to monitor normal postnatal weight loss.

More than 20% of neonatal caregivers report that an APGAR score, used to assess the physical condition of the newborn, is not recorded for any of the neonates in their care.

Table 6.3 Usual care for newborns in maternities

PROCEDURE	PERCENT OF PROVIDERS		
	ALL NEONATES	SOME NEONATES	NONE
APGAR score recorded	75.2	2.5	20.7
Clean baby with oil	77.7	4.1	17.4
Suction with catheter	52.1	35.5	10.7
Swaddling	86.0	5.8	6.6
Prophylactic eye treatment	81.0	8.3	10.7
Prophylactic treatment of genitals	72.7	14.9	12.4
Weighing of baby	86.8	3.3	9.9
Immediate skin-to-skin contact	29.8	59.5	10.7
Immediate breastfeeding	44.6	50.4	5.0
Number of respondents	121	121	121

Provider attitudes and beliefs about care and feeding of the neonate

Experts now believe that that restricting a mother's contact with her infant in the hours and days after delivery can lead to less affectionate maternal behavior. Restrictions on maternal – newborn contact have also been shown to reduce the duration of successful breastfeeding. Nevertheless, only 30% of neonatal care providers say that immediate skin-to-skin contact for mother and baby is standard practice for all neonates, and more than 10% say that this is never done in their facility (Table 6.3).

[9] World Health Organization (1997) *Essential Newborn Care and Breastfeeding: Workshop Proceedings*, Geneva: WHO

[10] Personal communication, Pauline Glatleider, consultant midwife.

All neonatal and delivery caregivers (in both maternities and polyclinics) were also asked their attitudes toward breast-feeding and skin to skin contact between mother and baby. About 93% of delivery and neonatal care providers report that a mother should be given her baby (skin-to-skin contact) immediately after delivery, and another 5% of maternity care providers and 2% of neonatal care providers say this should be done within the first hour after birth (data not shown). Only 11% of neonatal caregivers and 14% of delivery care providers think the mother should keep the baby 'as long as she wants'.

One of the major changes the WIN Project will try to effect is the attitude toward and practice of exclusive breastfeeding among hospital staff and mothers. To assure the optimal chance of successful breastfeeding, counselors recommend that babies be put to the breast immediately after delivery, and at most, not more than an hour following delivery.

We see from the data in Table 6.3 that less than half of providers say that putting the baby to the breast immediately is routine in their facility.

In Russia, most infants are still routinely segregated in central nurseries. 'Rooming in', when the baby and mother stay together in the same room 24 hours a day, is a recent innovation. We asked all providers of delivery and neonatal care whether they themselves offer rooming-in to their patients (Table 6.4). More than 80% of caregivers working in maternities say they offer this option to their patients. However, few providers report that there are no contraindications for mothers to have babies with them day and night. When asked what contraindications would prevent a mother 'rooming-in' with her infant, the majority of providers said that mother or infant illness would indicate separation of mother from her newborn, and about 25% of providers said that a Cesarean delivery was a contraindication.

Table 6.4 Main contraindications for rooming-in

	PERCENT OF CLIENTS	
	DELIVERY CARE PROVIDERS	NEONATAL CARE PROVIDERS*
Rooming-in offered to patients*	83.5	80.2
Contraindicatons:		
Mother is ill	66.9	76.7
Child is ill or weak or premature	52.9	60.0
Mother is in intensive care	57.9	40.8
Baby is in intensive care	57.0	53.3
Cesarean birth	26.4	23.3
Mother does not want	14.9	9.9
No contraindications	0.1	2.5
Other	6.6	4.9
Number of respondents	121	121

* Excludes neonatal caregivers in children's polyclinics.

Advice on infant feeding

All delivery and neonatal care providers were asked if they counseled women about breast-feeding. Sixty-two percent of delivery care providers and 79% of neonatal caregivers reported that they counsel postpartum women about how to breast-feed.

Among the common recommendations, more than 75% of neonatal caregivers and 50% of delivery caregivers report that they recommend exclusive breastfeeding to their clients (Table

6.5). Similar proportions of these providers also recommend that a mother wash her nipples each time she breastfeeds. Most providers also agree that women should feed 'on demand' rather than on a set schedule. Nevertheless, more than half of neonatal caregivers (who are those most frequently cited by women as resources for breast-feeding advice) and almost 40% of delivery caregivers recommend supplementing breast milk with water.

Table 6.5 Usual breast-feeding recommendations to postpartum clients

	PERCENT OF PROVIDERS	
	DELIVERY CARE PROVIDERS[+]	NEONATAL CARE PROVIDERS[+]
Counsel women about breastfeeding	61.7	78.8
Recommend the following to mothers:		
Exclusive breast-feeding	52.9	75.4
Supplementing with formula	18.2	33.1
Supplementing with water	36.4	51.5
Increasing milk supply by feeding on demand	44.6	64.2
Breastfeeding on a schedule	14.9	21.2
Restricting duration of breastfeeding	23.1	33.8
Washing nipples at each breast-feed	52.1	70.4
Number of respondents	121	260

[+] Column percentages do not add to 100 because multiple responses were allowed.

The majority of both delivery and neonatal care providers (90%) say that babies should be put to the breast in the first hour after birth (Table 6.6).

Table 6.6 Advice on timing of first breast feeding

	TYPE OF PROVIDER	
	NEONATAL	DELIVERY
Begin breastfeeding:		
During first hour after birth	90.0	89.3
1 to 6 hours	7.3	7.4
After one day	1.2	0.0
Other	0.4	2.5
Don't know/no opinion	1.2	0.8
Total	100.0	100.0
Number of respondents	260	121

Caregivers were also asked their opinion about the frequency of breast feeds. While 73% of delivery care providers said they recommend feeding 'on demand', only 55% of neonatal care providers gave this response. Advice these providers give to mothers about supplementation (when they tell mothers to start giving anything other than breast milk) ranges widely among both groups of caregivers, as the data shown in Table 6.7 suggest. 36% of neonatal caregivers and 40% of delivery caregivers advise some kind of supplementation before the infant reaches three months of age. More than 60% of delivery caregivers and almost 60% of neonatal caregivers advise supplementation before four months.

Table 6.7 Advice on when mothers should supplement breastfeeding

	TYPE OF PROVIDER	
	NEONATAL	DELIVERY
Begin supplementing at:		
Less than one month	9.3	12.3
1	12.7	13.7
2	13.2	13.7
3	22.0	21.9
4	15.6	11.0
5	10.7	1.4
6	11.2	6.8
12	0.5	2.7
Other	4.9	16.4
Total	100.0	100.0
Number of respondents	205	74

When asked what conditions might contraindicate breastfeeding, 85% of neonatal caregivers and 46% of delivery care providers gave mother's illness as a reason (Table 6.8). Child illness or prematurity also accounted for a large number of responses to this question; more than 65% of neonatal caregivers and 38% of delivery caregivers said that a weak or ill baby was reason not to breast-feed. Few of those who counsel mothers about breastfeeding believe that there are no contraindications.

Table 6.8 Main contraindications for breast-feeding

	% OF CASES BY REASON	
	DELIVERY CARE PROVIDERS	NEONATAL CARE PROVIDES
Mother is ill	46.3	85.4
Child is ill or weak	38.0	65.8
When baby is premature	16.5	20.4
Nipple/breast problems	11.6	20.8
Cesarean birth	5.0	5.8
When mother does not have enough milk	1.7	1.7
When mother does not want	5.8	5.8
When baby refuses	3.3	10.7
No contraindications	4.1	0.1
Other reasons	9.9	15.7
Number of respondents	121	260

Finally, we examined these providers' ideas about what actually constitutes 'exclusive breastfeeding' and for how long they recommend it. 28% of neonatal caregivers and 27% of delivery care providers replied that they recommend feeding breast milk and nothing else except vitamins, minerals, or medicine for the first six months.

Key WIN Indicators

Of those who counsel on breastfeeding, 28% of neonatal caregivers and 27% of delivery caregivers recommend exclusive breastfeeding for the first six months

Postpartum Client Experiences and Perceptions

Postpartum women were interviewed in maternities shortly before discharge (74%), or when visiting a children's polyclinic (25%) or women's consultation center (0.9%) shortly after the birth. Of these latter 84 women, all had given birth within the previous 6 months and all but 8 of the infants were 4 months old or less at the time of the interview.

Fertility intentions

We can see from Table 6.9 that the intentions of these women, interviewed in the immediate postpartum period, are somewhat different from those of antenatal clients (compare with Table 5.10). While few women want to wait less than three years until their next birth, a smaller proportion of women in the middle age group – 25 to 34 – are sure, shortly after their delivery, that they want no more children. Almost half of these women say they don't know how long they want to wait until the next birth. More postpartum women in the youngest age group say they want no more children when they are compared with antenatal clients between 15 and 24 (26% of postpartum compared with 14% of antenatal clients in this age group).

Table 6.9 Future pregnancy intentions by age group

	10-YEAR AGE GROUP			TOTAL
	15–24	25–34	35–45	
Wait 3 years or less	21.8	16.7	*	18.6
Wait more than 3 years	35.3	13.0	*	23.7
Want no more children	26.3	25.4	*	25.3
Don't know	16.7	44.9	*	32.4
Total	156	138	18	312

*Estimates based on less than 25 cases omitted.

Contraceptive experience

We also see from the data displayed in Table 6.10 that only 17% of postpartum women report that they became pregnant while using a contraceptive method. Most of these women were using methods that are very effective if used properly. More than 40% were using reversible medical methods of contraception, and 35% were using condoms. Less than 15% were using traditional, and less effective, methods to prevent pregnancy. Like the antenatal clients (Table 5.8), only about 15% of postpartum clients using barrier methods became pregnant while actually using the method; just over 50% of those using traditional methods became pregnant while using the method.

Table 6.10 Distribution of last method used by whether pregnancy occurred while using the method

	TOTAL % OF ALL USERS USING EACH METHOD	% OF USERS OF METHOD TYPE	% OF USERS OF METHOD TYPE WHO BECAME PREGNANT
Medical Reversible	N= 100	42.6	8.0
Pills	28.1		
IUD	12.8		
Injection	1.3		
Post-coital pill	0.4		
Barrier	N=102	43.4	15.7
Condoms	35.7		
Spermicide/Creams/Jelly	7.7		
Traditional	N=33	14.0	(53.1)
LAM	0		
Natural Family Planning	8.9		
Withdrawal	4.7		
Other	0.4		
Total	100.0	100.0	17.4
Number of respondents	235	41	

Estimates based on 25-49 cases in ( ).

The fertility intentions of these women – only about one in four women desire no more children – and their past record of contraceptive failure suggest that postpartum counseling about reversible medical contraceptive choices is needed by virtually all of these women.

Postpartum Client Experiences and Perceptions

Three hundred and twenty-four women were interviewed during the postpartum period. Most of these women (75%) were interviewed very close to their day of discharge from a maternity ward. The rest were bringing their infants for neonatal check-ups at children's polyclinics.

We first asked women about their birth experience. Table 6.11 shows that the prevalence of Cesarean section deliveries varied among the three cities, with 22% of women in Perm reporting that they had a Cesarean delivery, while fewer in Veliky Novgorod (15%) and Berezniki (17%) reported that their delivery was by Cesarean section.

Table 6.11 Percent of postpartum women reporting type of delivery by city of residence

	PERCENT OF CASES			
	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Cesarean sections	14.6	22.1	16.7	18.5
Vaginal deliveries	85.4	77.9	83.3	81.5
Number of respondents	103	149	72	324

The reasons for a Cesarean section are quite varied, ranging from almost one-quarter of women who said that a previous Cesarean section was the reason for the recent one. Pregnancy-induced hypertension, prolonged labor, and a big baby were each cited as reasons by about 15% of women.

Table 6.12 Percent distribution of reasons for Cesarean section

REASON	PERCENT OF CLIENTS
Fetal distress	6.7
Pregnancy-induced hypertension	15.0
Prolonged labor	15.0
Prolonged pushing	1.7
Baby too big	15.0
Previous Cesarean	23.3
Other	23.3
Total	100.0
Number of respondents	60

Only one woman who had a vaginal delivery reported that forceps were used.

We then asked these women the same questions about their routine care that we asked providers of care during delivery. Table 6.13 shows the responses of women in each city, but caution is urged in interpreting differences between cities because sample size is small.

Table 6.13 Practices during labor and delivery reported by clients

	PERCENT YES			
	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Perineal shave*	89.3	92.6	100	93.2
Axillary shave**	68.9	61.8	59.7	63.6
Enema	97.1	87.2	95.8	92.3
IV solution	75.7	89.3	90.3	85.2
	54.4	40.9	48.6	46.9
Medicine to induce labor				
Medicine for pain relief	57.3	55.7	83.3	62.3
	18.4	28.2	30.6	25.6
Restricted to bedrest				
Restricted in what you could eat	23.3	31.5	55.6	34.3
Restricted in what you could drink	20.4	26.2	45.8	28.7
	63.1	50.3	52.8	54.9
Artificial rupture of membranes				
Had an episiotomy	20.4	40.9	18.1	29.3
Ambulatory during labor	76.7	63.1	62.5	67.3
Not allowed to sit up	39.8	75.2	40.3	56.2
	93.2	98.0	97.2	96.3
No close person supporting at birth				
Prefer no close person at next birth	63.1	55.7	70.8	61.4
Number of respondents	103	149	72	324

* Of these clients, about 30% in each city reported that they themselves had done the shave at home.
** Between 50% and 60% of these women performed the underarm shave at home.

More than half of women in Veliky Novgorod and Perm, and more than 4 out of 5 women in Berezniki reported that they were given pain medication. Of these women, 89% reported that they wanted the pain relief medication (data not shown).

Sixty-seven percent of women reported that they were allowed to walk while in labor and another 4% said that they did not ask permission to walk. Fifty-six percent of women reported that they were not allowed to sit up during labor. These practices appear to vary widely from city to city,

but the numbers in each city are small. Nevertheless, it appears that women in Perm are less likely to be allowed to assume a sitting position during labor than are women in other cities.

Forty-two percent of postpartum women reported that their antenatal care provider told them they had problems with their pregnancy. Of these women, almost all were told what the problems were, and Table 6.14 displays the distribution of reasons that women reported. Almost half of women who were classified as 'high risk' said that they risked a pre-term delivery. Gestosis (including hypertension of pregnancy) (26%) and anemia (15%) were other frequently cited reasons.

Table 6.14 Distribution of problems during pregnancy

REASON	PERCENT OF CLIENTS
Risk of loss of a pregnancy (preterm delivery)	42.5
Gestosis*	26.0
Oedema	8.7
Renal disease	3.9
Toxemia	4.7
Albuminuria	3.9
Anemia	15.0
Don't remember	0.8
Other	34.6
Number of respondents	127

* See previous section for explanation.

Family-centered maternity care

Some of the main characteristics of "maternity care oriented toward participation of family members" are closer contact between mother and baby (including rooming-in and immediate, exclusive breastfeeding), more involvement by other family members in antenatal preparations, and support during labor and delivery and in the postpartum period.

Less than 4% of women reported that their husband or a close person was present during labor or birth (Table 6.13). This practice is clearly very unusual in participating facilities at this time, but almost 40% of all women report that they would like a close person present if they have another birth (Table 6.15). At the time of the survey about 60% of women said they would prefer no one close to them to be present during delivery. Although the idea is quite new, there is a gap of almost 40% of women who did not have support from a family member during childbirth, but would like to have such support. Their choice of a support person is shown in Table 6.15.

Table 6.15 Women's choice of support during labor

	PERCENT OF CLIENTS
Had no close person present at birth	96.3
Support preference, if another birth:	
No one	61.4
Baby's father	28.1
Other family member	5.9
Friend	0.3
Don't know	4.3
Number of respondents	324

Only 25% of postpartum women reported receiving any information about family-centered maternity care before the birth, and of these, only 13 women reported choosing this option.

Of all postpartum women interviewed, 38% reported that their baby stayed in their room day and night (rooming-in), but 62% of these women reported that the baby was taken to a nursery for the first night after birth (table 6.16). Of the women who did not have 'rooming-in', only 13% (25 women) reported being offered the option. The remaining 87% said they were never offered the option of 'rooming-in'. In contrast, more than 80% of providers told us that they offer this option to their patients (Table 6.4).

Table 6.16 Postpartum clients reports of 'rooming-in' experiences

ROOMING-IN EXPERIENCE	PERCENT OF CLIENTS
Had baby with her night and day	38.3
Of those who had rooming-in (N=124)	
Baby taken to nursery 1st night	61.6
Of those who did not have rooming-in (N=200)	
Offered rooming-in option	12.5
Number of respondents	324

As mentioned earlier, skin-to-skin contact between mother and baby assists early bonding of mother and baby and is now widely recommended. We see that more than half of all women report that they did experience such contact immediately after the birth. Nevertheless, 15% of women who were about to be discharged from the maternity reported not yet having such contact.

Table 6.17 Timing of first skin-to-skin contact

	PERCENT OF CLIENTS
Immediately	55.2
Within 24 hours	18.2
24 hours of more	9.3
Not yet	15.1
Don't know	1.9
Missing	0.3
Number of respondents	324

Breast feeding attitudes and practice

Now we turn to examine reports of postpartum women about their experiences of breastfeeding. The data shown in Table 6.18 show some variations between cities, but these differences should be interpreted cautiously given the small number of respondents in each city. Sixty-two percent of women say their caregivers recommended exclusive breastfeeding, and very few say they were advised to supplement breast milk with baby formula. More than half of all postpartum women were advised to supplement with water (which is therefore not exclusive breastfeeding). About half of breastfeeding counselors also say they advise supplementing with water (Table 6.5). Women could answer 'yes' to each item, and some say they received conflicting advice: to increase milk supply by feeding on demand (43%) and to schedule feeding times (39.6%). Almost 90% of women were instructed to wash their nipples at each feeding, but slightly fewer women in Perm report this recommendation (82%).

Table 6.18 Breast-feeding recommendations from facility staff reported by women[+]

	V. NOVGOROD	PERM	BEREZNIKI	TOTAL
Exclusive breast-feeding	91.3	53.4	38.9	62.2
Supplementing with formula	9.7	6.8	5.6	7.4
Supplementing with water	60.2	45.9	23.6	45.5
Increasing milk supply by feeding on demand	56.3	45.3	19.4	43.0
Breastfeeding on a schedule	55.3	28.4	40.3	39.6
Restricting duration of breastfeeding	17.5	16.2	2.7	13.6
Washing nipples at each breast-feed	91.3	82.4	95.8	88.2
Number of respondents	103	148	72	323

[+] Columns do not add to 100% because multiple responses were allowed.

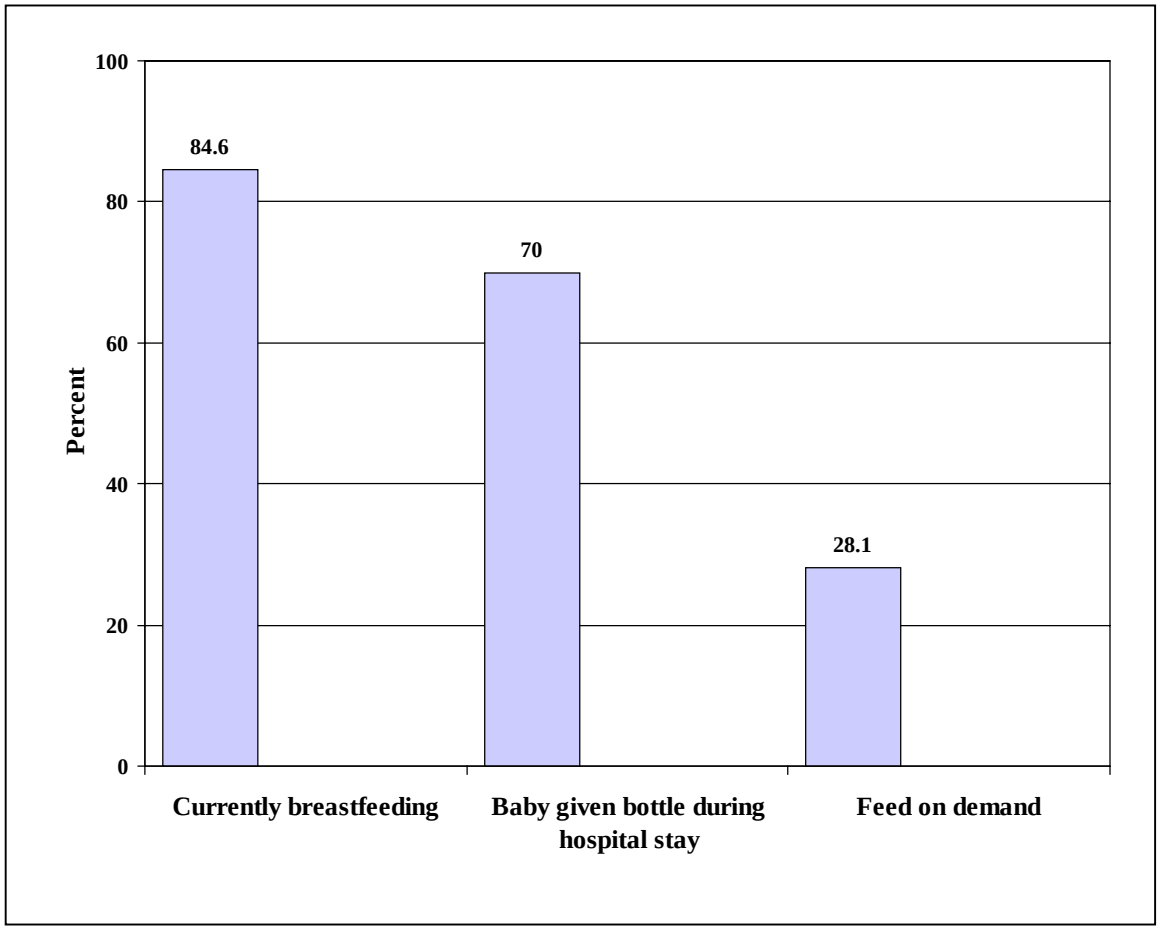
In Figure 6.1 we see that almost 85% of postpartum women reported that they are currently breastfeeding[11], but nearly 70% of these women say their baby was given something else besides breast milk to drink during their hospital stay (another 7% were unsure). Nearly two-thirds of women report feeding on a fixed schedule. Only 28% of breastfeeding women say they feed 'on demand'.

Table 6.19 Breastfeeding practices reported by postpartum women

	PERCENT OF CLIENTS
Currently breastfeeding	84.6
Number of respondents	324
Of Those currently breastfeeding (N=274)	
Baby given drink from bottle during hospital stay	70.0
Frequency of breast feeds	
On schedule	66.8
On demand	28.1
As often as they bring baby	5.1
Timing of first breast-feed	
Immediately (within one hour)	37.7
Within 1- 24 hours of delivery	39.5
More than one day after delivery	16.0
Don't know/did not breastfeed	6.8

[11] Of mothers interviewed before discharge from a maternity, 88% reported they were currently breastfeeding.

Figure 6.1 Postpartum women's breastfeeding practices



Nearly 40% of all postpartum women report that they first breast-fed their baby within an hour of delivery, but 16% of women report that the first feed did not occur until more than 24 hours after delivery.

Among the 50 women who were not breastfeeding, the most frequent reason cited was that the baby was ill or weak (40%). Another 38% of non-breastfeeding women said they did not have enough milk. Almost all of these women said that prior to the birth they had intended to breastfeed (data not shown).

Postpartum women were also asked who was the best source of advice about breastfeeding. Like antenatal clients (Table 5.16), most answered that a pediatrician or neonatologist was the best person to consult (Table 6.20).

Table 6.20 Postpartum clients opinion on source of breastfeeding advice

BEST PERSON TO CONSULT ABOUT BREASTFEEDING	PERCENT OF CLIENTS
Obstetrician	10.2
Neonatologist/pediatrician	67.0
Midwife	3.1
Nurse	4.0
Friend	1.9
Family member	10.5
Other	1.8
Don't know	1.5
Number of respondents	324

We asked these postpartum women to tell us what the term 'exclusive breastfeeding' meant to them. 49% told us the 'correct' definition: breast milk and nothing else except vitamins, minerals or medicine.

It seems that women know what exclusive breastfeeding means, but that providers do not recommend this for the full first six months of the infant's life.

Key WIN Indicator

49 % of postpartum clients can correctly define exclusive breastfeeding.

Contraceptive knowledge and plans for postpartum use

As with our antenatal clients, few postpartum women believe that breast-feeding can be used as a contraceptive (e.g. the lactational amenorrhea method, or LAM). Only 12% of all postpartum women said 'yes' to this question and almost a quarter were unsure of the answer. The 39 women who said 'yes' were asked under what conditions breastfeeding could be an effective contraceptive. Only six women correctly supplied all three conditions (baby less than 6 months, no menses, and exclusive breastfeeding on demand).

Only 10% of postpartum women reported that someone at the facility had discussed the LAM method with them, and only 2 postpartum clients said that they were planning to use LAM (of those who knew which method they would use).

Table 6.21 Postpartum women's beliefs about breastfeeding as contraception

	PERCENT OF CLIENTS
Postpartum women who believe breastfeeding can be used as a contraceptive	
Yes	12.0
No	62.3
Don't know	25.6
Know all three conditions when it is effective (N=39)	(15.4)
Provider at this facility discussed LAM	10.8
Number of respondents	324

Estimates based on 25-49 cases in ( ).

Postpartum women were also asked what method of contraception they were planning to use. More than half of these women knew what method they would use, and most – almost 3 or every

4 clients – named a medical method of birth control. Three percent said they would use sterilization – a tubal ligation or vasectomy. Although almost half of women had used a barrier method before this pregnancy, less than one-quarter planned to use one in future, and very few (less than 10%) planned to use a traditional method of contraception.

Table 6.22 Plans for postpartum contraception

	PERCENT OF CLIENTS
Knows what contraceptive method she will use	50.9
Distribution of methods	
Medical	72.1
Barriers	20.6
Traditional	4.2
Sterilization	3.0
Number of respondents	165
Of those who plan to use method later, they will start to use plan	
Immediately after the birth	2.8
After a follow-up visit	30.8
After my menses return	3.5
When sexual relations start	21.7
Other	17.5
Not sure	23.8
Number of respondents	143

Few women said they planned to start using the method immediately. Almost 25% of these women were unsure when they would start contraceptive use and many will delay use until they have a postpartum check-up.

Almost half of these women (44%) said they were advised by their doctor to use the named method, 12% were advised by another woman, 12% by someone else, and 30% reported that no one had advised them to use the method. Ninety-six percent reported that the method they planned to use was their method of choice.

Of those who did not already know which method they would use, 89% were planning to use a contraceptive method at some later date and, while more were unsure of the method they will use, almost half reported wanting to use a reversible medical method.

Table 6.23 Type of method mentioned by those who have not yet chosen a method

	PERCENT OF CLIENTS
Medical Reversible	43.4
Barrier	5.6
Traditional	0.7
Sterilization	0.7
Other	8.4
Don't Know	41.3
Number of respondents	143

Key WIN Indicator

51% of postpartum clients know what contraceptive method they will use.

93 % of these clients report they will use a modern method of birth control postpartum (medical, reversible or sterilization, barrier) and 72 % will use a medical method.

7. CONTRACEPTION AND CONTRACEPTIVE COUNSELING

Provider Knowledge and Attitudes

Just under half of providers (45%) said that they gave information and counseling about contraceptives to women attending their facility, but the proportion of women's health care providers who do so varies by city, and by the type of facility where they work and their training. Table 7.1 shows these distributions.

Providers in children's polyclinics (neonatologists/pediatricians and infant nurses) were least likely to do contraceptive counseling, while all providers working in hospital gynecology units said that they do such counseling (Table 7.1).

Table 7.1 Percent of providers who counsel clients about contraceptive use

PROVIDER CHARACTERISTICS	COUNSELS ABOUT CONTRACEPTIVES	DOES NOT COUNSEL	NUMBER OF RESPONDENTS
City			
Veliky Novgorod	33.0	67.0	194
Perm	50.9	49.1	234
Berezniki	55.9	44.1	68
Type of health facility			
Maternity	43.4	56.7	217
Hospital gynecology unit	*	*	13
Women's consultation	86.0	14.0	107
Children's polyclinic	6.3	93.8	144
Family planning center	86.7	13.3	15
Medical specialty			
Obstetrician or gynecologist	92.6	7.4	162
Neonatologist or pediatrician	6.7	93.3	135
Midwife	49.5	50.5	111
Infant nurse	1.3	98.7	79
Other	*	*	8
Total	**44.6**	**55.4**	**495**

* Estimates based on less than 15 cases omitted.

Women's health providers in Veliky Novgorod are less likely to report that they do contraceptive counseling than do providers in other cities. (Only about one-third say they counsel, compared to about one-half of providers in Perm and Berezniki, data not shown). These providers were then asked which methods they most commonly discussed with clients, and for specific methods, what counseling they gave.

The data in Table 7.2 show the methods mentioned by providers in order of frequency. IUDs, condoms and oral contraceptives were the methods most often mentioned by providers; 9 of every 10 providers mentioned these methods. Next most common methods mentioned were two much less effective methods – natural family planning (rhythm method) and spermicides. Tubal ligation (female sterilization) is mentioned by almost half of all providers, which is surprising in light of the reports from other sources that few women have received such methods. (Less than 2% of women in these cities were currently using this method, according to the *WIN Project Baseline Household Survey 2000: Report of Main Findings*). Forty percent of providers say they discuss the lactational amenorrhea method of contraception, which is also a surprisingly large

proportion of providers, given the very few clients who mentioned hearing about LAM from a health care provider (Tables 5.17 and 6.21).

Table 7.2 Methods providers most commonly discuss with clients, in order of prevalence

METHOD	% MENTIONING EACH METHOD
IUD	90.5
Condoms	90.0
Pills	89.1
Natural family planning	67.4
Spermicide/cream/jelly	59.7
Tubal ligation	49.3
Lactational Amenorrhea method (LAM)	40.7
Injections/Depoprovera	33.0
Diaphragm/cervical cap	24.0
Implants/Norplant	18.6
Vasectomy	11.3
Other	1.4
Number of providers	221

Those providers who mentioned oral contraceptives were asked what accompanying advice they give to women who will use the method. Results are displayed in Table 7.3.

Table 7.3 Percent of providers who report giving different types of advice to pill users

ADVICE GIVEN TO PILL USERS	PERCENT OF PROVIDERS
When in cycle to begin taking the pill	
With first 5 days of menstrual bleeding	90.8
Other answers	7.1
Don't know	2.0
STD advice to at-risk pill users +	
Continue to use pill alone	5.1
Continue with the pill but use a condom	65.5
Switch from the pill to the condom	15.7
Stop using any type of contraception	1.5
Counsel client on STDs/HIV or refer for counseling	32.5
Other	7.6
Unsure, don't know	4.1
Symptoms for which user should return to doctor+	
Chest pain, shortage of breath	21.9
Headache	52.0
Vision loss or blurring	14.8
Abdominal pain	44.4
Leg pain	25.0
Excessive/frequent bleeding	66.3
Spotting	50.0
Late menses	41.8
No symptoms	0.1
Other	40.3
Number of respondents	196

+Percentages do not add to 100% because providers could give more than one answer.

Those who mention IUDs were also asked about specific advice they give. Their answers are displayed in Table 7.4.

Table 7.4 Advice providers report giving to IUD and injectable contraceptive users

ADVICE GIVEN TO IUD & INJECTABLE CONTRACEPTIVE USERS	PERCENT OF PROVIDERS+
Symptoms for which IUD user should return to doctor	
Heavy discharge	48.5
Abnormal spotting or bleeding	86.0
Expulsion or cannot feel threads	35.5
Abdominal pain	86.0
Late menses	49.5
Other	29.0
Number of respondents	200
Symptoms for which user of injectable contraceptives should return to doctor	
Chest pain, shortage of breath	22.9
Headache	34.3
Vision loss or blurring	12.9
Abdominal pain	40.0
Leg pain	24.3
Excessive/frequent bleeding	70.0
Spotting	42.9
Late menses	40.0
Frequent Urination	1.4
Depression	14.3
Other	28.6
Don't know	2.9
Number of respondents	70

+Percentages do not add to 100% because providers could give more than one answer.

Contraception for breast feeding women

Ninety providers (40% of all those who give contraceptive counseling, but only 18% of all women's health care providers) report mentioning LAM as a contraceptive method. Yet less than 10% of antenatal clients and about 10% of postpartum clients report hearing about LAM from their caregivers. Eighty-eight providers report that they discuss a back-up method to use when LAM is no longer effective. However, only 74 of these providers (82%) indicated which method or methods they advise LAM users to adopt as a back-up method if they intend to continue to breast-feed. As shown in Table 7.5, IUDs were the method cited most often (71% of providers who named a method mentioned this), followed by tubal ligation and low-estrogen ("mini") pills mentioned by 65% and 47% of providers, respectively. More than 20% of providers mentioned other types of daily pills, all of which are contraindicated for breast feeding mothers.

Table 7.5 Advice to women about back-up methods for lactational amenorrhea method

ADVICE GIVEN ABOUT BACK-UP METHODS FOR LACTATIONAL AMENRRHEA METHOD	PERCENT OF PROVIDERS[+]
Method to use after LAM	
Pills ('mini')	47.3
IUD	71.6
LAM	20.3
Injectables	2.7
Tubal ligation	64.9
Condoms	12.2
Other	20.3
Pills (regular)	21.6
Number of respondents	74
When a postpartum woman should begin using the back-up method	
When she is 6 months postpartum	52.7
When her menses return	32.4
When she starts to give the baby anything other than breast milk	48.6
Missing	16.0
Number of respondents	88

[+]Percentages do not add to 100% because providers could give more than one answer.

LAM is no longer an effective method of contraception when any of the following conditions is met: when the baby reaches 6 months of age, when supplementation is introduced OR when menses return. The quality of counseling provided by those recommending LAM as a contraceptive method was examined by asked 'when should a postpartum woman start the back-up method?

As we can see from the second panel of Table 7.5, no more than half of all providers mentioned each indication that LAM is no longer an effective method for a woman to use as a contraceptive. We also looked to see if any providers did provide all three correct answers to the indications for when LAM is no longer effective. Only 14 providers (15.5% of the 90 who said they counsel about the method) mentioned all three conditions under which LAM was effective.

All providers, regardless of whether they themselves provide contraceptive counseling were asked their opinion of the contraceptive method best suited to a breast feeding woman. Condoms were the choice most frequently mentioned (45% of providers), followed by the IUD (37%). More than 13% of providers were unsure or did not answer. The lactational amenorrhea method (LAM) was mentioned by almost 12% of respondents, 10% mentioned mini-pills (brand name low-estrogen pills) and almost 10% mentioned 'natural family planning' (the rhythm method).

Table 7.6 Percent of providers stating preference for methods for breast feeding woman

METHOD	% OF PROVIDERS WHO COUNSEL+	% OF ALL PROVIDERS+
Pills (mini - low estrogen)	19.5	10.7
IUD	43.9	36.8
LAM	18.6	11.5
Injectables/Depoprovera	5.9	2.6
Tubal ligitation	1.4	1.0
Condoms	59.3	45.5
Natural family planning	6.8	9.7
Pills (regular)	4.1	3.4
Other	6.3	5.6
Unsure D/K	2.3	13.3
Number of respondents	221	497

+ Columns do not add to 100% because multiple responses were allowed.

Providers who counsel about contraception more often mention low-estrogen oral contraceptives (mini-pills) and LAM than do all women's health care providers combined (Table 7.6). Nevertheless, the level of awareness of both low-estrogen pills and LAM as options for breastfeeding mothers in quite low.

Male involvement in family planning and reproductive health

All providers were also asked whether they had discussed family planning with a client's partner. Only 10% of all providers and 18% of providers who do contraceptive counseling (54 of the 221 providers) answered 'yes' to this question (Table 7.7).

Providers were also asked who should make the decision about which contraceptive method to use. Thirty-six percent responded that the woman and her partner should make the decision jointly, 30% thought that the woman alone should make the decision, and 23% thought the decision should be made by the woman and her doctor. 17% of providers answered that the doctor should make the decision alone. (These percentages do not add to 100 percent because providers were allowed to give multiple answers to this question.)

Table 7.7 Practice and attitudes of providers toward male involvement in family planning of all women's health care providers

PRACTICE & ATTITUDES TOWARD MALE INVOLVEMENT IN FP	PERCENT OF PROVIDERS
Who should make the choice of contraceptive method+	
Woman alone	30.6
Her doctor	16.9
Woman and partner	36.0
Woman and her doctor	22.7
Other/not sure	1.2
Discussed family planning with a woman's husband or partner	10.9
Believe that provision of reproductive health services to men will improve women's health	90.5
Supports providing reproductive health services for men in facility	61.1
Number of respondents	497

+ Multiple responses allowed.

All providers were also asked if they thought that provision of reproductive health services to men would improve women's health. More than 90% of those who responded answered 'yes' to this question. Nevertheless, fewer providers (a little more than 60%) said they support the idea of providing reproductive health services to men at their own facility.

Client Contraceptive Counseling Experience and Attitudes

We also asked clients about their experience of counseling, if any, provided in the facility they were attending. As we see in Table 7.8, few antenatal and postpartum clients report having discussed contraception with medical staff. A larger proportion of abortion clients (just over 40%) had received counseling, but this is not consistent with the reports of abortion providers that 92% talk to their clients about contraception at the time of the abortion procedure (Table 4.3).

Table 7.8 Client experience of contraceptive counseling by type of service

	% OF ANTENATAL CLIENTS	% OF POSTPARTUM CLIENTS	% OF ABORTION CLIENTS
Medical staff talked about how to avoid another unplanned pregnancy?	22.8	19.1	41.1
Number of respondents	491	324	489
Presentation of pregnancy prevention information			
Pregnancy prevention information given respectfully	93.8	100	95.5
Questions encouraged	91.1	95.2	94.5
Partner participated	1.0	3.2	4.0
Number of respondents (86 partners of abortion clients and 6 partners of antenatal clients were present at the facility)	112	62	201
Providers explained method, side effects, and what to do if problems	-	79.5	82.9
Number of respondents	-	73	234
Want partner to participate in pregnancy prevention counseling?	74.1	85.5	74.9
Number of respondents	489*	62+	455**
Ever discussed contraception with partner	78.2	81.5	90.1
Think men should have access to reproductive health services at this facility	88.2	-	90.6
Number of respondents	491	324	463
Where to seek advice about contraception (after leaving facility)			
Women's consultation center	88.6	88.6	82.0
Friend	3.7	4.3	2.7
Family planning clinic	0	0.3	7.8
Other	4.7	3.7	5.5
Don't know	2.2	3.7	1.5
Number of respondents	491	324	473

* Excludes 2 women who had no regular partner. + Asked only of postpartum women who had received counseling. ** Excludes 8 women whose partner attended a counseling session that day and 26 women without a regular partner.

In any case, women who do receive contraceptive counseling are satisfied with the way it is delivered. More than 90% of all clients said the information was conveyed to them in a respectful manner, and their questions were encouraged.

If they had received counseling from a provider at the facility, we also asked abortion and postpartum women more specific questions about the quality of that counseling. We asked: did the provider explain how to use the method, describe possible side effects or problems, and tell her what to do if she did experience problems. Eighty percent of postpartum women who were counseled and 83% of abortion women who received counseling reported that their provider had discussed all three elements (Table 7.8).

Most women had discussed contraception with their partners at some time in the past, and at least 75% (more than 85% of postpartum women) want their partners to participate in family planning counseling.

Differences between cities

When we look at differences between the cities (Table 7.9) we can see that Veliky Novgorod has a much higher proportion of abortion clients who report that contraceptive methods were discussed with them at the time of the abortion. Two-thirds of women in Veliky Novgorod report receiving counseling or information, but less than a third of abortion clients in Perm and Berezniki report such counseling. Contraceptive counseling for antenatal clients appears to be more typical in Perm and Veliky Novgorod than in Berezniki, but only half as many postpartum women in Perm receive counseling at the maternity as do postpartum clients in Veliky Novgorod and Berezniki.

Table 7.9 Contraceptive counseling by city of residence and type of client

TYPE OF CLIENT	CITY			
	V. NOVGOROD	PERM	BEREZNIKI	TOTAL (N)
Antenatal (any visit)	24.5	29.3	9.4	22.8 (491)
Postpartum	24.3	12.1	26.4	19.1 (324)
Abortion	67.8	30.8	27.9	41.1 (489)

8. SEXUALLY TRANSMITTED INFECTIONS AND DOMESTIC VIOLENCE

The WIN Project wants to ensure that providers assess all clients for their risk of contracting a sexually transmitted infection (STI). All providers were asked how they currently assess women for risk of sexually transmitted infections.

We see from the distribution of responses in Table 8.1 that about three-quarters of all providers who counsel women about contraception said women with multiple partners are at risk of STIs. Other frequently mentioned responses were women who inject drugs or women whose partners do so. Women whose partners have other partners was mentioned by about 20% of providers (and 29% of those who do contraceptive counseling). These latter criteria may be more difficult to assess, especially if the woman herself is unaware of a partner's promiscuity or drug use. Almost half of providers also gave other answers to this question.

Table 8.1 Percent of providers mentioning various criteria they use to assess whether a woman is at risk of sexually transmitted infection

CRITERIA USED TO ASSESS RISK	PERCENT OF PROVIDERS WHO COUNSEL ABOUT CONTRACEPTION[+]	PERCENT OF ALL PROVIDERS[+]
If woman's partner has other partners	28.5	18.3
If she has more than one partner	74.2	47.7
If she injects drugs	32.6	22.7
If her partner injects drugs	15.4	11.1
If she asks for a test	10.4	5.6
Not provider's responsibility	8.6	29.6
Other	48.4	40.8
Total number of respondents	221	497

[+] Columns do not add to 100% because multiple responses were allowed.

Thirty percent of all providers interviewed replied that such assessment of risk was not their responsibility.

Among those who consider it their responsibility to take action if they identify a woman at risk, 98% said that they would order lab tests, diagnose her or refer her for diagnosis (data not shown). Only 18% of providers would arrange for a follow-up visit after testing. Ten percent said they themselves would counsel the woman, and 42% would refer the woman to someone else for counseling.

Providers were also asked about what action they would take if they see a woman who shows signs of domestic violence (Table 8.2). Almost half of all providers (48%) replied that they do not see victims of domestic abuse. Among other responses given, the most frequently cited action was to refer the woman to a special center for forensic tests (such centers are provided by the government in Russia), followed by 14% who would refer her to the militia (police). Only 10% said they would counsel the woman, 6% said they would refer her to social services or to a psychologist (9%).

Table 8.2 Actions providers report they take in cases of domestic violence

	PERCENT OF PROVIDERS MENTIONING
Counsel her	10.5
Ask permission to talk to partner	0.6
Refer her to social services	6.2
Refer to psychologist	8.5
Refer her to militia	13.9
Examine her	3.0
Refer to special center for forensic tests	16.7
Other	9.5
Do not see victims of domestic violence	47.7
Number of respondents	497

Client experience of domestic violence

Antenatal and abortion clients were asked if they themselves had experienced violence or threats of violence at the hands of their partners during the previous year. (Postpartum women were not asked these questions, because it was felt to be inappropriate at the time.) Three percent of antenatal clients and 6% of abortion clients said that they had been victims of such abuse (by either a partner or former partner). This is very similar to the proportion of women who reported experience of domestic violence in household surveys. Between 5% and 7% of women of reproductive age in these same cities reported experiencing threats or actual acts of violence at the hands of a partner during the previous year (David, *et al, op cit.*).

Client reports of risk behavior during pregnancy

The WIN Project also wants to know about the prevalence of various behaviors that, if practiced during pregnancy, can harm mother or the developing foetus. Twelve percent of antenatal clients who are smokers report that they continue to smoke during pregnancy, but this amounts to only 6% of all antenatal clients. In contrast, almost 20% of all postpartum clients reported that they smoked during their pregnancy. Many of these postpartum women now report that they are not current smokers. It may be that some current smokers among the both groups of clients did not want to disclose behavior that they know is not good for their babies.

Table 8.3 Risk behavior during pregnancy reported by clients

REPORTS OF RISK BEHAVIORS	% OF ANTENATAL CLIENTS	% OF POSTPARTUM CLIENTS
Smoking cigarettes		
Ever smoked cigarettes	51.1	-
Currently smoke (of 251 ever-smokers)	12.0	-
Smoked during pregnancy	-	18.2
Currently smoke (of 59 who smoked in pregnancy)	-	28.8
Frequency of drinking during pregnancy		
One to three times per week	1.6	1.5
Less than once per week	25.7	32.7
Not at all	72.7	65.7
Number of respondents	491	324

9. INFORMATION, EDUCATION AND COMMUNICATION

We also wanted to know how much information was provided to women through different communication channels in the pre-intervention period. All clients were asked if they had received any information through a variety of possible channels (Table 9.1).

Table 9.1 Percent of clients and providers (all services) reporting channels of information

INFORMATION CHANNELS	ANTENATAL	POSTPARTUM	ABORTION	PROVIDERS
Given/took brochure or educational material to read away from facility	25.3	33.6	25.2	-
Gave material to woman to read	-	-	-	30.2
Attended a group talk today	18.9	11.4	27.4	-
Provider gave group talk today	-	-	-	34.3
See any poster or information sheet at facility	91.2	70.1	72.8	-
See a video or TV presentation at facility	4.3	0.0	0.4	-
Number of cases	491	324	489	496

We see from the data displayed in Table 9.1 that, while many clients report seeing a poster or information sheet in the facility, only one-quarter of antenatal and abortion clients and one-third of postpartum clients report being given reading material to take home with them. About 30% of providers reported supplying women with reading material. About 10% of postpartum clients, nearly 20% of antenatal clients, and almost 30% of abortion clients reported attending a group talk. Few clients reported seeing a TV or video presentation at the facility.

Provider Reports of Topics Discussed with Clients

We asked providers whether they had discussed certain topics with their clients on the day of the interview. About 10% of providers report that they discussed 'family-centered maternity care' with clients on the day of interview (Table 9.2). (Of course, providers of abortion services would not be expected to discuss this topic, or breastfeeding and care of the newborn, with their own clients, but they are included in the denominator.) Almost half of all providers reported discussing smoking or alcohol use with clients, while only 2% said they had discussed domestic violence with a client that day.

Table 9.2 Provider reports of information discussed with clients

TOPIC	% DISCUSSING THIS TOPIC WITH CLIENTS TODAY
Family-centered maternity care	11.9
Nutrition	57.5
Breastfeeding	55.0
STDs or HIV/AIDS	32.3
Smoking or use of alcohol	45.6
Care of the newborn	42.5
Domestic violence	2.0
Number of respondents	496

Client Reports of Information Received about Family-Centered Maternity Care

Prior to the start of the project interventions, we also wanted to discover what information women said they received about topics related to family-centered maternity care (FCMC). While women would not necessarily recognize this term – 'family-centered maternity care' – they could report whether they had discussed certain components of family-centered care with their providers. This information, displayed in Table 9.3, provides us with some proxy information to compare with post-intervention results.

Table 9.3 Reports on information about family-centered maternity care

INFORMATION RECEIVED ABOUT FAMILY-CENTERED MATERNITY CARE	% ANTENATAL CLIENTS	% POSTPARTUM CLIENTS
During antenatal visits, discussed preparations for delivery	-	55.4
Partner / family member participated in these discussions	5.7	26.9
Staff discussed partner/family participation during childbirth	20.8	-
Staff discussed 'rooming-in' option	15.5	-
Received any information about "maternity care oriented to family participation" option for the birthing process	1.4	24.7
Of those (N=78), selected family-centered maternity care option	-	16.6
Number of respondents	491	324

More than half of postpartum women reported that they discussed preparations for delivery during their antenatal visits, but of those, only about one-quarter reported that a partner or other family member participated in those discussions (Table 9.3). Of antenatal clients, only 1 in 5 reported that their provider had discussed family participation during childbirth, and only 15% reported discussing the option for 'rooming-in' with their newborn. Very few antenatal clients and less than one-quarter of the postpartum women reported receiving any information about the FCMC option. Most of the postpartum women who selected the FCMC option say they would choose it again (11 of 13 respondents).

10. GENERAL SATISFACTION

Finally, we asked some questions of both clients and providers about how they would rate the services in their facility. Clients are often reluctant to say anything critical about the staff or the facility, and more likely to report that they are satisfied with services, when interviewed at the facility. We have therefore included some items in this section of the questionnaire to obtain a more objective assessment, such as 'would you recommend a friend to come to this facility?' Results from these client interviews should be interpreted cautiously, and with the recognition that they may suggest a more positive assessment than is real.

Clients' Rating of Service Received

We asked clients first to rank the facilities where they were interviewed on 4 dimensions – hygiene, comfort, competence of health professionals, and courtesy of health professionals.

Overall rankings for each service were quite high, but mean scores mask a fair amount of variation among respondents (Table 10.1). In general, rankings for provider courtesy are quite high, while women rank facilities lower on comfort. Antenatal and abortion facilities were rated slightly less well than postpartum facilities on 'competence of providers'.

Table 10.1 Mean rating given by clients for attributes of each service (1 = 'good' 3 = 'poor')

TYPE OF CLIENT	ATTRIBUTES OF SERVICES RECEIVED			
	HYGIENE	COMFORT	COMPETENCE OF PROVIDERS	COURTESY
Antenatal	1.56	1.84	1.82	1.32
Abortion	1.39	1.75	1.84	1.25
Postpartum	1.42	1.75	1.30	1.10

The distribution of rankings (all clients combined) for each city separately and in total is shown in Table 10.2 below.

Table 10.2 Client rankings given to facilities (all clients combined) by city

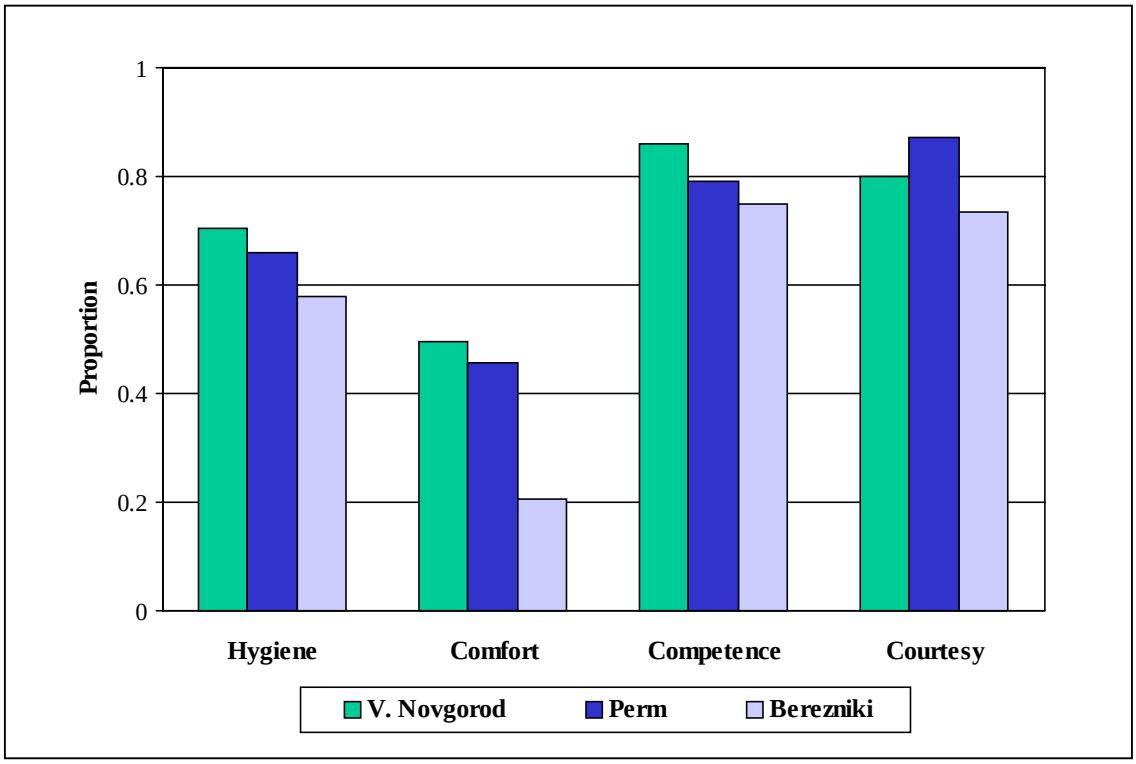
RANKING GIVEN TO FACILITY	CITY			TOTAL
	V. NOVGOROD	PERM	BEREZNIKI	
Hygiene				
Good	70.3	66.1	57.9	65.3
Fair	25.2	30.8	38.4	31.0
Poor	1.0	2.4	3.7	2.3
Don't know	3.4	0.6	0.0	1.3
Total (Number of respondents)	100.0 (388)	100.0 (588)	100.0(328)	100.0 (1304)
Comfort				
Good	49.7	45.7	20.7	40.6
Fair	42.0	44.6	58.2	47.2
Poor	5.7	9.4	20.1	11.0
Don't know	2.6	0.3	0.9	1.1
Total (Number of respondents)	100.0 (388)	100.0 (588)	100.0 (328)	100.0 (1304)
Competence of health professionals				
Good	85.8	79.3	75.0	80.1
Fair	10.0	11.4	16.0	12.2
Poor	0.3	0.7	0.9	0.6
Don't know	3.9	8.7	8.0	7.0
Total (Number of respondents)	100.0 (388)	100.0 (588)	100.0 (328)	100.0 (1304)
Courtesy of health professionals				
Good	79.9	87.1	73.5	81.5
Fair	17.3	10.7	25.3	16.3
Poor	0.8	1.7	0.9	1.2
Don't know	2.1	0.5	0.3	0.9
Total (Number of respondents)	100.0 (388)	100.0 (588)	100.0 (328)	100.0 (1304)

When we combine all three types of clients, we can compare the proportion who give rankings of 'good' to their facility on the four criteria – hygiene, comfort, competence of health professionals and courtesy of health professionals. We can see in Table 10.2 and Figure 10.1 on the following page that clients rank the comfort of facilities as "good" least often and among cities, clients in Berezniki have the least favorable impression of the comfort provided by their facilities. Less than half of all clients consider the comfort of their facilities to be "good", and in Berezniki, this falls to only 20% of all clients.

In all, clients are mostly satisfied with the competence and courtesy of their health professionals (more than 3 of every 4 clients rate their facility as "good" on these criteria), but again, Berezniki fares least well among the cities. Nevertheless, a fairly large number of clients answered "don't know" to this question, 8% or more in Perm and Berezniki. Some of these responses may reflect clients' genuine inability to judge the competence of their health providers, but some may reflect a reluctance on the part of dissatisfied clients to give an outright rating of "poor" to their providers during the facility-based interview.

Almost 90% of Perm clients rate the courtesy of their health professionals as "good", slightly more than clients in the other two cities. And, less than 60% of clients in Berezniki rank their facility as "good" in hygiene, while two-thirds of clients in Perm and 70% of clients in Veliky Novgorod rate the hygiene of their facilities "good".

Figure 10.1 Proportion of clients (all types combined) giving a ranking of "Good" to their facility on four criteria, by city



Satisfaction with maternity services

Postpartum women who were interviewed before discharge from the maternity were asked to report on several indicators of their satisfaction with the services they had received. The distribution of their responses is shown in Table 10.3. In panel A of the table, we see that women report high levels of satisfaction with the facility, overall, but a large proportion of women in each city – and more than half of women in Berezniki – were not satisfied with the degree of privacy in their consultations with medical staff. In Perm and Berezniki, only about three women in every five said they would recommend a friend to deliver in the same facility.

Table 10.3A Percent of postpartum clients answering questions about satisfaction with maternity services

	CITY			TOTAL
	V. NOVGOROD	PERM	BEREZNIKI	
Satisfied overall	100.0	93.2	88.9	93.8
Enough privacy in consultations with doctor or midwife	65.3	74.0	44.4	66.7
Medical staff permitted questions	95.3	83.0	80.0	85.3
Recommend a friend to deliver here	98.0	63.0	57.8	69.2
Number of respondents	49	146	45	240

Table 10.3B Percent of postpartum clients ranking facility where they were interviewed on four criteria (N=324)

	GOOD	FAIR	POOR	DON'T KNOW
Hygiene	65.1	29.9	4.6	0.3
Comfort	43.5	41.7	14.2	0.6
Competence of health professionals	85.5	12.0	0.3	2.2
Courtesy of health professionals	82.4	16.7	0.9	-

In Panel B of the same table, we see that almost 15% of postpartum women rated the facility they were attending as "poor", and about 35% of these women said that hygiene in the facility was only "fair" or "poor".

Satisfaction with antenatal services

Antenatal clients were asked a series of similar questions. As with postpartum women, most antenatal clients (almost 90%) were fairly satisfied with overall services (Table 10.4a), but a large proportion in each city again felt that they did not have enough privacy during consultations with medical staff. Only about 70% of women in Veliky Novgorod and Perm, and less than 60% of women in Berezniki said they would recommend this facility to a friend.

Table 10.4A Percent of antenatal clients answering questions about satisfaction with antenatal care services

	CITY			TOTAL
	V. NOVGOROD	PERM	BEREZNIKI	
Satisfied overall	95.7	83.1	86.6	87.6
Enough privacy in consultations with doctor or midwife	70.5	68.4	57.5	66.2
Medical staff permitted questions (of N=299who had questions)	87.1	95.0	91.4	92. 3
Recommend a friend to come to this facility	71.2	69.8	56.7	66.6
Number of respondents	139	225	127	491

Table 10.4B Percent of antenatal clients ranking facility where they were interviewed (N=491)

	GOOD	FAIR	POOR	DON'T KNOW
Hygiene	62.3	34.4	4	2.4
Comfort	38.7	50.9	8.4	2.0
Competence of health professionals	73.3	17.9	1.0	7.7
Courtesy of health professionals	78.0	18.9	1.8	1.2

The facility's level of comfort was also rated lowest by antenatal clients; hygiene also was rated less than adequate ("good") by almost 40% of these women.

Satisfaction with abortion services

Privacy was also a problem for abortion clients: less than half of these women in Veliky Novgorod and Berezniki, and only 60% of women in Perm reported that they had enough privacy during medical consultations. Moreover, 15% of women who said they had questions reported that medical staff did not permit them to ask the questions. (This varied widely by city, as shown in Table 10.5a.) Almost all women in Veliky Novgorod said they would recommend the facility to a friend who needed an abortion (95%). In Perm, this fell to only about 75% of women who would recommend a friend to come to that facility. In Berezniki only about half of abortion

clients would recommend the facility (Table 10.5b), and 40% said 'there is no other choice' (data not shown), which is hardly an indication of satisfaction.

Table 10.5A Percent of abortion clients answering questions about satisfaction with abortion services

	City			Total
	V. Novgorod	Perm	Berezniki	
Satisfied overall	97.3	92.5	92.2	93.9
Enough privacy in consultations with doctor or midwife	48.6	59.8	45.0	52.6
Medical staff permitted questions (of those who had questions, N=226)	96.2	68.0	87.0	85.0
Recommend a friend to come to this facility	94.5	76.7	53.5	75.9
Number of respondents	146	214	129	489

Table 10.5B Percent of abortion clients ranking facility where they were interviewed (N=489)

	Good	Fair	Poor	Don't know
Hygiene	68.5	28.4	2.2	0.8
Comfort	40.7	47.2	11.5	0.6
Competence of health professionals	83.4	6.5	0.4	9.6
Courtesy of health professionals	84.5	13.5	0.8	0.8

Like the other clients, abortion clients were most dissatisfied with the level of comfort in the facility where the abortion was performed (only 40% rated their facility as "good"), and more than 30% of these women also ranked hygiene as less than optimal ("good") (Table 10.5B). Almost 10% of abortion clients said they could not judge the competence of health professionals at the facility. In general abortion clients rated their health providers more highly in terms of competence and courtesy than did antenatal clients (see Table 10.4B), and about as highly as postpartum women ranked their providers on these criteria (see Table 10.3B). Only about 15% of abortion and postpartum clients rated their providers less than "good" on these criteria.

Provider and client attitudes toward men receiving services

One way to improve women's reproductive health is to involve their partners in reproductive health care, and to improve the preventive behaviors that lead to improved health of men. We asked abortion and antenatal clients, as well as health providers, if they thought that men should have access to reproductive health services at the facility. We can see from the data displayed in Table 10.6 that most abortion clients in all three cities are in favor of providing such services to men. Most antenatal clients were also in favor of providing male reproductive health services at women's consultation centers, but only 75% of antenatal clients in Veliky Novgorod approved. Providers attitudes were slightly less favorable (only about 60% of providers approved), but varied widely between cities. Less than half of providers in Veliky Novgorod were in favor of providing services to men at their facility, but this rose to more than 65% of providers in Perm and nearly 90% of providers in Berezniki.

Table 10.6 Attitudes of clients and providers to extending reproductive health services to men

MEN SHOULD HAVE ACCESS TO SERVICES AT THIS FACILITY	CITY			TOTAL (N)
	V. NOVGOROD	PERM	BEREZNIKI	
Abortion clients	91.8	91.1	88.4	90.6 (489)
Antenatal clients	75.5	94.7	90.6	88.2(491)
Providers	46.4	65.8	86.8	61.1(494)

Providers' Rating of Services

Finally, we asked medical staff to rank their own facilities on three of the same criteria which the clients had ranked. We did not ask providers to rate competence and courtesy of professionals, but did ask them to rank their facility for the privacy offered to clients. Their responses are displayed in Table10.7.

Table 10. 7 Provider rankings given to their own facilities

RANKING GIVEN FOR FACILITY	CITY			TOTAL
	V. NOVGOROD	PERM	BEREZNIKI	
Hygiene				
Good	56.2	48.9	55.9	52.7
Fair	32.5	41.6	36.8	37.4
Poor	10.3	9.4	7.4	9.5
Don't know	1.0			0.4
Comfort				
Good	36.6	27.5	11.8	28.9
Fair	41.2	52.4	52.9	48.1
Poor	21.6	20.2	35.3	22.8
Don't know	0.5			0.2
Privacy				
Good	25.3	27.0	11.8	24.2
Fair	38.7	42.5	36.8	40.2
Poor	33.0	30.0	50.0	33.9
Don't know	3.1	0.4	1.5	1.6
Total (Number of respondents)	100 (194)	100 (233)	100 (68)	100 (495)

Broadly, providers in these facilities were harsher in their assessments of facility hygiene, comfort and privacy than their clients were. More than one-fifth of providers rated the comfort in their facilities "poor", and less than 30% rated their facility as "good" in this respect. Only about one-half of medical staff rated their facility's hygiene as "good", and almost 10% rated hygiene as "poor". And one of every three caregivers said that the privacy afforded to patients at their facility was poor. Less than a quarter of these medical professionals thought that privacy for clients was optimal.

These findings suggest that medical caregivers are aware of, and unhappy with, conditions in their facilities, and may be voicing frustration with conditions that they lack the power to improve.

11. CONCLUSIONS

This survey is one component of the WIN Project evaluation, and has provided baseline data on key indicators of project performance. These baseline data will also be used to help stimulate action by policy-makers to change long-entrenched but unproven or unnecessary practices.

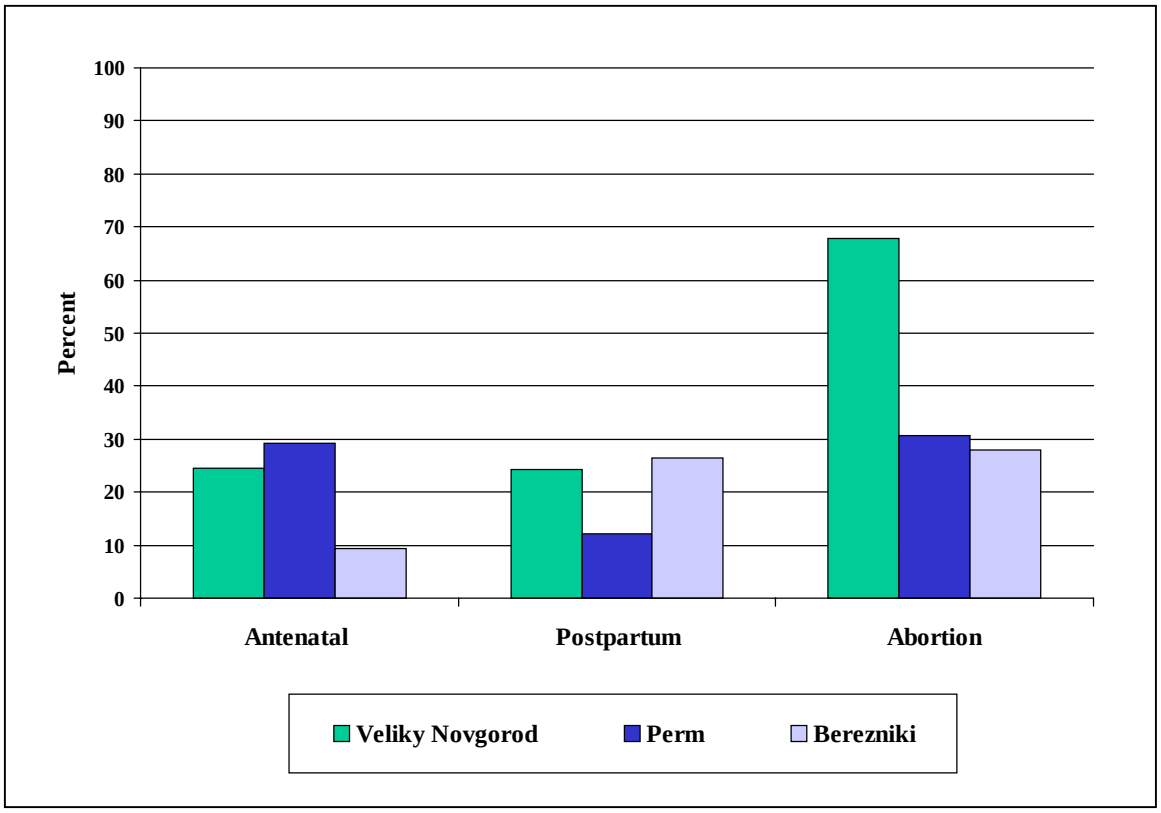
A total of 548 providers were contacted for interview. Of these providers, 51 refused to be interviewed and one started but did not complete the interview. Completion rates were fairly similar for all specialties and ranged from a high of 96% of all providers in Veliky Novgorod to only 87% in Perm and 90% in Berezniki who agreed to be interviewed. The total number of providers successfully interviewed was 497.

Quantitative measures of key program effectiveness indicators using both provider and client reports were calculated. Monitoring indicators include knowledge of exclusive breastfeeding, women ambulatory during labor, women delivering with support of a family member, postpartum contact between mother and newborn, and the percent of postpartum and post-abortion clients who receive family planning counseling prior to discharge.

One of the main findings is that prevalence of abortion and repeated abortion by all types of clients is high. Of women who had had more than one pregnancy (including the current one) more than three-quarters of antenatal, postpartum and abortion clients had least one previous abortion. Of those repeat abortion clients, 40% had terminated a pregnancy by abortion within the previous calendar year.

Another conclusion of this baseline study is that contraceptive counseling in all women's health services is currently inadequate. Only 23% of antenatal clients reported discussing contraception with medical staff at the facility. Only 41% of post-abortion and 19% of postpartum clients received family planning counseling prior to discharge.

Figure 11.1 Percent of clients who discussed contraception with medical staff

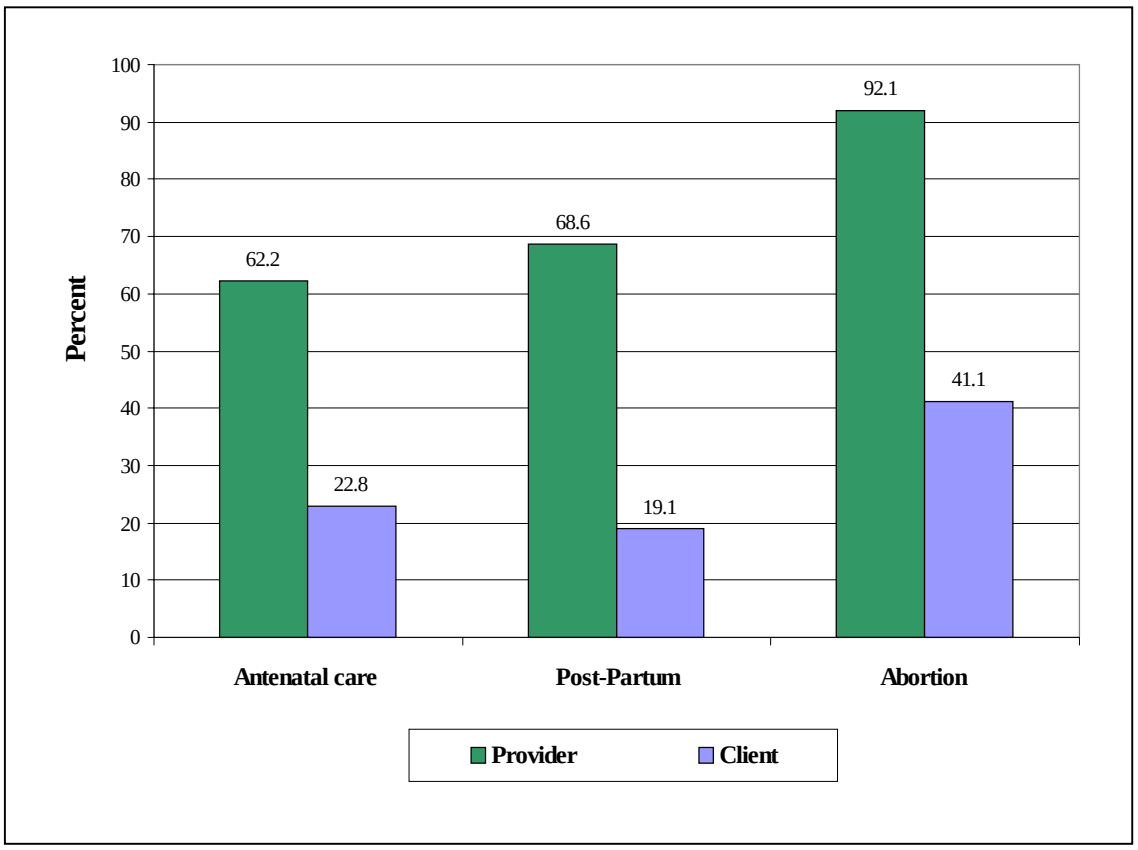


But 62% of antenatal caregivers, 69% of delivery caregivers and 92% of abortion providers reported that they discuss contraception with their clients. This means either that clients don't understand that providers are trying to counsel them, or that providers know that they 'should' discuss contraception with their clients, but don't always do so, in practice. It may also mean that some providers counsel all clients, but some providers don't counsel most of their clients, if any.

For example, we see in Figure 11.1 that less than half of all abortion clients have been reached by the providers who say they give contraceptive information to their clients.

As these data about contraceptive counseling suggest, information obtained from providers was sometimes inconsistent with client reports, and this discrepancy is shown when we combine provider and client reports in Figure 11.2.

Figure 11.2 Provider and client reports: discussed contraception



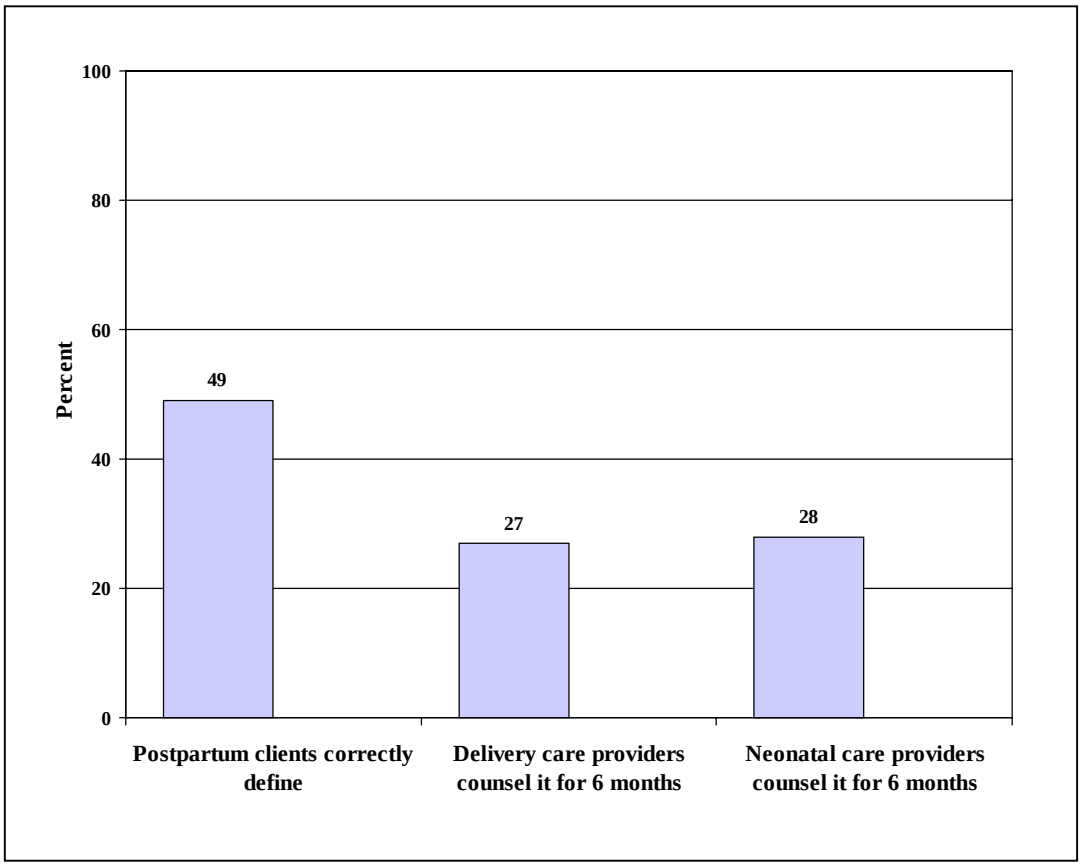
Another conclusion we can draw is that many women can define exclusive breastfeeding, but few providers actually counsel women to breastfeed exclusively for the first 6 months. Postpartum women were asked "what does the term 'exclusive breastfeeding' mean to you?" The 'correct' answer is breast milk and nothing else, except vitamins, minerals or medicine, and 49% of postpartum women could define this correctly (Figure 11.3). Providers were asked "when you talk to your clients about breastfeeding, what do you recommend they feed baby in the first 6 months?" We see in the figure that only a little more than 25% of delivery care and neonatal caregivers tell their clients to breastfeed exclusively for a full six months. Furthermore, almost one-half of all postpartum women (46%) said they were advised to supplement their breast milk with water.

Women start out to breastfeed their babies. Eighty-four percent of postpartum women reported that they were currently breastfeeding. Of those, 70% said their baby was given something to drink from a bottle during the hospital stay (and 7% did not know if the baby got something else). Yet only 28% of postpartum women said they fed 'on demand' and 67% fed on a schedule (5% said when the staff brought the baby to mother).

Further examples of inconsistencies between reports from providers and clients were found.

For example, 80% of delivery care providers reported offering 'rooming-in' to mothers, but only 38% of mothers said their baby stayed with them day and night. More than half of these babies (62%) were taken to the nursery for the first night. Of mothers who did not have rooming-in, 87% said they were never offered the option.

Figure 11.3 Exclusive breastfeeding: client knowledge and provider counseling

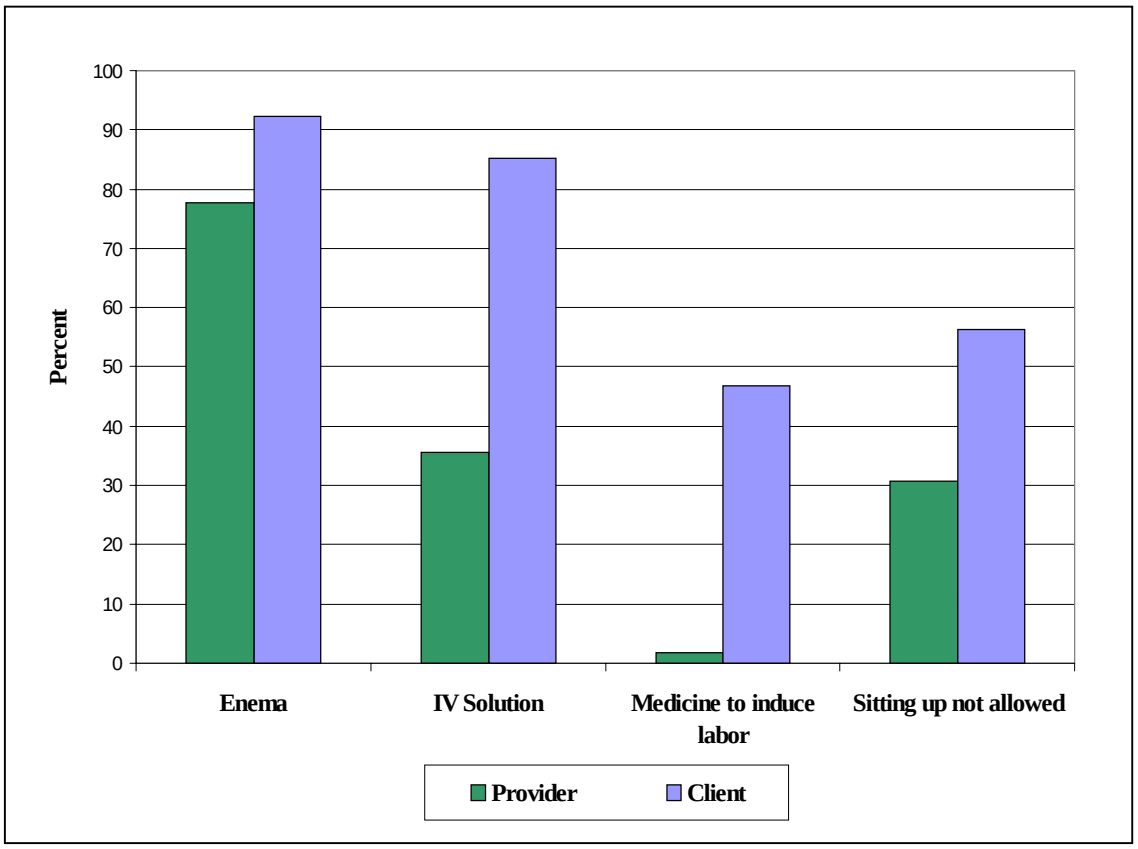


One of the characteristics of 'family-centred maternity care' is closer contact between mother and baby and more involvement by other family members in antenatal preparations for the birth, and support during labor and in the postpartum period. We found that in participating facilities, 96% of women said they had no close person supporting them at the birth.

Other discrepancies highlight issues of quality of care provided to women: 90% of abortion providers said they explain the procedure to clients prior to performing an abortion, yet only 56% of clients reported receiving such information.

The data displayed in Figure 11.4 shows results of reports by delivery caregivers about 'usual practice' in their facility, and compares these reports to those from women just recently delivered in these same facilities.

Figure 11.4 Reports of delivery care practices by providers and clients



Seventy-eight percent of providers said an enema was usual practice for all women (22% said only for some women). Nevertheless, 92% of postpartum women report having an enema. thirty-six percent of providers said IV solution was usual practice for ALL women (64% said only for some women), but 85% of postpartum women report having an IV solution during labor. Only two percent of providers said medicine to induce was usual practice for all women (98% said only for some women), but almost half of postpartum women (47%) report that their labor was induced. Thirty-one percent of providers said allowing women to sit up during labor was the usual practice for all women, and 56% of postpartum women report they were not allowed to sit up during their labor.

These and other findings should be used to stimulate discussion and action among facility staff and policy-makers.

Quantitative data obtained using sound methodologies are essential for project evaluation. These data can also be used to attain project objectives by providing a firm basis for policy discussions. Providing medical practitioners with information about women's opinions of the care they currently receive and desire to participate in decisions regarding their own care can assist programs aimed at changing long-entrenched but unproven or unnecessary practices.

Key WIN Indicators

Indicators related to abortion

76% of abortion clients, 75% of postpartum women, and 78% of antenatal clients who had more than one pregnancy had had a previous abortion.

40% of repeat abortion clients (gravidity 2 or more) had terminated a pregnancy by abortion within the previous calendar year

41% of post-abortion women received or were offered family planning counseling on the day of the abortion at the facility where the abortion took place.

More than 75% of abortion clients who know what method they will use name a medical reversible method and more than 90% name a modern method – medical reversible, sterilization or barrier.

48% of these women discussed use of their chosen method with a member of facility medical staff.

Of these latter women, 83% said that the person had clearly explained how the method works, described the possible side effects, and explained what to do in case of problems with the method (an indicator of the quality of counseling provided).

Indicators related to breastfeeding

% of providers who can correctly define 'exclusive breastfeeding'

Proxy Indicators:

74 % of antenatal care providers say they discuss exclusive breastfeeding with their clients.

47 % say they recommend giving only breast milk and nothing else (except vitamin and mineral supplements or medicine) for the first 6 months.

Of those who counsel on breastfeeding, 28% of neonatal caregivers and 27% of delivery caregivers report that they recommend exclusive breastfeeding for the first six months

56.0% of antenatal clients can correctly define 'exclusive breastfeeding'

49 % of postpartum clients can correctly define 'exclusive breastfeeding'.

Indicators related to contraceptive use

51% of postpartum clients know what contraceptive method they will use.

93 % of these clients report they will use a modern method of birth control postpartum (medical, reversible or sterilization, barrier) and 72 % will use a medical method.

79% of contraceptive users (all clients combined) report using modern methods (medical or barrier methods) prior to this pregnancy.

32.5% of contraceptive users (all clients combined) were using medical methods (oral, IUD, injections, implants, post-coital pill).

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